SA2003RF0081

December 22, 2003

VIA PERSONAL DELIVERY

The Honorable Bill Lockyer
Attorney General
1300 I Street
Sacramento, CA 95814

Re: Request for Title and Summary- Initiative Constitutional Amendment

Dear Mr. Lockyer:

Pursuant to Article II, Section 10(d) of the California Constitution and Section 9002 of the Elections Code, I hereby request that a title and summary be prepared for the attached initiative constitutional/statutory amendment. Enclosed is a check for $200.00. My residence address is attached.

All inquires or correspondence relative to this initiative should be directed to Nielsen, Merksamer, Parrinello, Mueller & Naylor, LLP, 1415 L Street, Suite 1200, Sacramento, CA 95814, (916) 446-6752, Attention: Richard D. Martland.

Thank you for your assistance.

Sincerely,

Joel Fox, Proponent

Enclosure: Proposed Initiative

SA2003RF0081

I, Joel Fox, acknowledge that it is a misdemeanor under state law (Section 18650 of the Elections Code) to knowingly or willfully allow the signatures on an initiative petition to be used for any purpose other than qualification of the proposed measure for the ballot. I certify that I will not knowingly or willfully allow the signatures for this initiative to be used for any purpose other than qualification of the measure for the ballot.

Joel Fox, Propønent

Dated: December 22, 2003

SA2003KF0081

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VIA PERSONAL DELIVERY

The Honorable Bill Lockyer
Attorney General
1300 I Street
Sacramento, CA 95814

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Thank you for your assistance.

Sincerely,

Christopher M. George, Proponent

Enclosure: Proposed Initiative

SA2003RF0081

I, Christopher M. George, acknowledge that it is a misdemeanor under state law (Section 18650 of the Elections Code) to knowingly or willfully allow the signatures on an initiative petition to be used for any purpose other than qualification of the proposed measure for the ballot. I certify that I will not knowingly or willfully allow the signatures for this initiative to be used for any purpose other than qualification of the measure for the ballot.

Christopher M. George, Proponent

Dated: December 22, 2003

SA2003CF0081

SEC. 1. This measure shall be known as the Workers' Compensation Reform Act

SEC. 2. Findings and Declarations

The People of the State of California find and declare that:

(a) Workers' compensation premiums have risen dramatically and unacceptably in California over the last few years. Premiums that were once a modest item in the cost of doing business have risen by as much as 200 to 300 percent, putting many small businesses out of business, and driving larger ones out of state.

(b) The average California business has seen its workers' compensation costs increase by 136 percent since 2000 alone. Workers' compensation costs have risen so high that experts believe they have replaced taxes and regulation as the biggest drag on our economy, and are the main reason we are losing jobs to other states.

(c) Thousands of California employers pay the highest workers' compensation premiums in the nation – more than twice the national average – while the California system pays benefits to injured workers that are among the lowest in the nation. Total costs have increased from $11 billion in 1998 to $29 billion in 2003.

(d) High costs to employers and low benefits to workers make bureaucrats and lawyers the major beneficiaries of a system that is broken.

(e) Our workers and our employers deserve better. California must have significant workers' compensation reform to lower costs to employers, protect worker benefits, and save hundreds of thousands of California jobs.

(f) This Act is intended to eliminate needless bureaucracy in order to reduce costs and eliminate delay or denial of necessary medical care and other services to injured workers.

SEC. 3. Section 4, Article XIV of the California Constitution is amended to read:

The Legislature is hereby expressly vested with plenary power, unlimited by any provision of this Constitution, to create, and enforce a complete system of workers' compensation, by appropriate legislation, and in that behalf to create and enforce a liability on the part of any or all persons to compensate any or all of their workers for injury or disability, and their dependents for death incurred or sustained by the said workers in the course of their employment, irrespective of the fault of any party. A complete system of workers' compensation includes adequate provisions for the comfort, health and safety and general welfare of any and all workers and those dependent upon them for support to the extent of relieving from the consequences of any injury or death incurred or sustained by workers in the course of their employment, irrespective of the fault of any party; also full provision for securing safety in places of employment; full provision for such medical, surgical, hospital and other remedial treatment as is requisite to cure and relieve from the effects of such injury; full provision for adequate insurance coverage against liability to pay or furnish compensation; full provision for regulating such insurance coverage in all its aspects, including the establishment and management of a state compensation insurance fund; full provision for otherwise securing the payment of compensation; and full provision for vesting power, authority and jurisdiction in an administrative body with all the requisite governmental functions to determine any dispute or matter arising under such legislation, to the end that the administration of such legislation shall accomplish substantial justice in all cases expeditiously, inexpensively, and without incumbrance of any character; all of which matters are expressly declared to be the social public policy of this State, binding upon all departments of the state government.

The Legislature is vested with plenary powers, to provide for the settlement of any disputes arising under such legislation by arbitration, or by an industrial accident commission, by the courts, or by either, any, or all of these agencies, either separately or in combination, and may fix and control the method and manner of trial of any such dispute, the rules of evidence and the manner of review of decisions rendered by the tribunal or tribunals designated by it; provided, that all decisions of any such tribunal shall be subject to review by the appellate courts of this State. The Legislature may combine in one statute all the provisions for a complete system of workers' compensation, as herein defined.

The Legislature shall have power to provide for the payment of an award to the State in the case of the death, arising out of and in the course of the employment, of an employee without dependents, and such awards may be used for the payment of extra compensation for subsequent injuries beyond the liability of a single employer for awards to employees of the employer.

Nothing contained herein shall be taken or construed to impair or render ineffectual in any measure the creation and existence of the industrial accident commission of this State or the state compensation insurance fund, the creation and existence of which, with all the functions vested in them, are hereby ratified and confirmed.

Nothing in the Article limits the powers reserved or granted to the people under Article II, including but not limited to the ability to establish forums and procedures for claims resolution to fairly and expeditiously resolve disputes.

SEC. 4. Section 1877.5 of the Insurance Code is amended to read:

1877.5. No insurer, agent authorized by an insurer to act on its behalf, or licensed rating organization who furnishes information, written or oral, pursuant to this article, and no authorized governmental agency or its employees who (a) furnishes or receives information, written or oral, pursuant to this article, or (b) assists in any investigation of a suspected violation of Section 1871.1, 1871.4, 11760, or 11880, or of Section 549 of the Penal Code, or of Section 3215, 3219, *or an investigation of a reported fraud claim pursuant to Section 3823* of the Labor Code conducted by a authorized governmental agency, shall be subject to any civil liability in a cause or action of any kind where the insurer, authorized agent, licensed rating organization, or authorized governmental agency acts in good faith, without malice, and reasonably believes that the action taken was warranted by the then known facts, obtained by reasonable efforts. Nothing in this chapter is intended to, nor does in any way or manner, abrogate or lessen the existing common law or statutory privileges and immunities of an insurer, agent authorized by that insurer to act on its behalf, licensed rating organization, or any authorized governmental agency or its employees.

SEC. 5. Labor Code 139.2 is amended to read:

139.2. (a) The administrative director shall appoint qualified medical evaluators in each of the respective specialties as required

for the evaluation of medical-legal issues. The appointments shall be for two-year terms.

(b) The administrative director shall appoint or reappoint as a qualified medical evaluator a physician, as defined in Section 3209.3, who is licensed to practice in this state and who demonstrates that he or she meets the requirements in paragraphs (1), (2), (6), and (7), and, if the physician is a medical doctor, doctor of osteopathy, doctor of chiropractic, or a psychologist, that he or she also meets the applicable requirements in paragraph (3), (4), or (5).

(1) Prior to his or her appointment as a qualified medical evaluator, passes an examination written and administered by the administrative director for the purpose of demonstrating competence in evaluating medical-legal issues in the workers' compensation system. Physicians shall not be required to pass an additional examination as a condition of reappointment. A physician seeking appointment as a qualified medical evaluator on or after January 1, 2001, shall also complete prior to appointment, a course on disability evaluation report writing approved by the administrative director. The administrative director shall specify the curriculum to be covered by disability evaluation report writing courses, which shall include, but is not limited to, 12 or more hours of instruction.

(2) Devotes at least one-third of total practice time to providing direct medical treatment, or has served as an agreed medical evaluator on eight or more occasions in the 12 months prior to applying to be appointed as a qualified medical evaluator.

(3) Is a medical doctor or doctor of osteopathy and meets one of the following requirements:

(A) Is board certified in a specialty by a board recognized by the administrative director and either the Medical Board of California or the Osteopathic Medical Board of California.

(B) Has successfully completed a residency training program accredited by the American College of Graduate Medical Education or the osteopathic equivalent.

(C) Was an active qualified medical evaluator on June 30, 2000.

(D) Has qualifications that the administrative director and either the Medical Board of California or the Osteopathic Medical Board of California, as appropriate, both deem to be equivalent to board certification in a specialty.

(4) Is a doctor of chiropractic and meets either of the following requirements:

(A) Has completed a chiropractic postgraduate specialty program of a minimum of 300 hours taught by a school or college recognized by the administrative director, the Board of Chiropractic Examiners~~,~~ and the Council on Chiropractic Education.

(B) Has been certified in California workers' compensation evaluation by a provider recognized by the administrative director. The certification program shall include instruction on disability evaluation report writing that meets the standards set forth in paragraph (1).

(5) Is a psychologist and meets one of the following requirements:

(A) Is board certified in clinical psychology by a board recognized by the administrative director.

(B) Holds a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology pursuant to Section 2914 of the Business and Professions Code, from a university or professional school recognized by the administrative director and has not less than five years' postdoctoral experience in the diagnosis and treatment of emotional and mental disorders.

(C) Has not less than five years' postdoctoral experience in the diagnosis and treatment of emotional and mental disorders, and has served as an agreed medical evaluator on eight or more occasions prior to January 1, 1990.

(6) Does not have a conflict of interest as determined under the regulations adopted by the administrative director pursuant to subdivision (o).

(7) Meets any additional medical or professional standards adopted pursuant to paragraph (6) of subdivision (j).

(c) The administrative director shall adopt standards for appointment of physicians who are retired or who hold teaching positions who are exceptionally well qualified to serve as a qualified medical evaluator even though they do not otherwise qualify under paragraph (2) of subdivision (b). In no event shall a physician whose full-time practice is limited to the forensic evaluation of disability be appointed as a qualified medical evaluator under this subdivision.

(d) *(1)* The qualified medical evaluator, upon request, shall be reappointed if he or she meets the qualifications of subdivision (b) and meets all of the following criteria:

~~(1)~~ *(A)* Is in compliance with all applicable regulations and evaluation guidelines adopted by the administrative director.

~~(2)~~ *(B)* Has not had more than five of his or her evaluations that were considered by a workers' compensation administrative law judge at a contested hearing rejected by the judge or the appeals board pursuant to this section during the most recent two-year period during which the physician served as a qualified medical evaluator. If the administrative law judge or the appeals board rejects the qualified medical evaluator's report on the basis that it fails to meet the minimum standards for those reports established by the administrative director or the appeals board, the administrative law judge or the appeals board, as the case may be, shall make a specific finding to that effect, and shall give notice to the medical evaluator and to the administrative director. Any rejection shall not be counted as one of the five qualifying rejections until the specific finding has become final and time for appeal has expired.

~~(3)~~ *(C)* Has completed within the previous 24 months at least 12 hours of continuing education in impairment evaluation or workers' compensation-related medical dispute evaluation approved by the administrative director.

~~(4)~~ *(D)* Has not been terminated, suspended, placed on probation, or otherwise disciplined by the administrative director during his or her most recent term as a qualified medical evaluator.

(2) If the evaluator does not meet any one of ~~these~~ *the* criteria *specified in paragraph (1)*, the administrative director may in his or her discretion reappoint or deny reappointment according to regulations adopted by the administrative director. In no event may a physician who does not currently meet the requirements for initial appointment or who has been terminated under subdivision (e) because his or her license has been revoked or terminated by the licensing authority be reappointed.

(e) The administrative director may, in his or her discretion, suspend or terminate a qualified medical evaluator during his or her term of appointment without a hearing as provided under subdivision (k) or (l) whenever either of the following conditions occurs:

(1) The evaluator's license to practice in California has been suspended by the relevant licensing authority so as to preclude practice, or has been revoked or terminated by the licensing authority.

(2) The evaluator has failed to timely pay the fee required by the administrative director pursuant to subdivision (n).

(f) The administrative director shall furnish a physician, upon request, with a written statement of ~~its~~ *his or her* reasons for termination of, or for denying appointment or reappointment as, a qualified medical evaluator. Upon receipt of a specific response to the statement of reasons, the administrative director shall review his or her decision not to appoint or reappoint the physician or to terminate the physician and shall notify the physician of ~~its~~ *his or her* final decision within 60 days after receipt of the physician's response.

(g) The administrative director shall establish agreements with qualified medical evaluators to assure the expeditious evaluation of cases assigned to them for comprehensive medical evaluations.

(h) (1) When the injured worker is not represented by an attorney, the medical director appointed pursuant to Section 122, shall assign three-member panels of qualified medical evaluators within five working days after receiving a request for a panel. If a panel is not assigned within 15 working days, the employee shall have the right to obtain a medical evaluation from any qualified medical evaluator of his or her choice. The medical director shall use a random selection method for assigning panels of qualified medical evaluators. The medical director shall select evaluators who are specialists ~~of the type selected by the employee~~ *whose specialty is relevant to the injury for which the evaluation is sought as identified by the report of the treating physician.* The medical director shall advise the employee that he or she should consult with his or her treating physician prior to deciding which type of specialist to request.

(2) The administrative director shall prescribe a form that shall notify the employee of the physicians selected for his or her panel. The form shall include, for each physician on the panel, the physician's name, address, telephone number, specialty, number of years in practice, and a brief description of his or her education and training, and shall advise the employee that he or she is entitled to receive transportation expenses and temporary disability for each day necessary for the examination. The form shall also state in a clear and conspicuous location and type: "You have the right to consult with an information and assistance officer at no cost to you prior to ~~selecting~~ the *selection of a* doctor to prepare your evaluation, or you may consult with an attorney. If your claim eventually goes to court, the workers' compensation administrative law judge will consider the evaluation prepared by the doctor you select to decide your claim."

(3) When compiling the list of evaluators from which to select randomly, the medical director shall include all qualified medical evaluators who meet all of the following criteria:

(A) He or she does not have a conflict of interest in the case, as defined by regulations adopted pursuant to subdivision (o).

(B) He or she is certified by the administrative director to evaluate in an appropriate specialty and at locations within the general geographic area of the employee's residence.

(C) He or she has not been suspended or terminated as a qualified medical evaluator for failure to pay the fee required by the administrative director pursuant to subdivision (n) or for any other reason.

(4) When the medical director determines that ~~an employee has requested an evaluation by a type of specialist that is appropriate for the employee's injury, but~~ there are not enough qualified medical evaluators of ~~that~~ *the appropriate* type within the general geographic area of the employee's residence to establish a three-member panel, the medical director shall include sufficient qualified medical evaluators from other geographic areas and the employer shall pay all necessary travel costs incurred in the event *of* the ~~employee selects~~ *selection of* an evaluator from another geographic area.

(i) The medical director appointed pursuant to Section 122, shall continuously review the quality of comprehensive medical evaluations and reports prepared by agreed and qualified medical evaluators and the timeliness with which evaluation reports are prepared and submitted. The review shall include, but not be limited to, a review of a random sample of reports submitted to the division, and a review of all reports alleged to be inaccurate or incomplete by a party to a case for which the evaluation was prepared. The medical director shall submit to the administrative director an annual report summarizing the results of the continuous review of medical evaluations and reports prepared by agreed and qualified medical evaluators and make recommendations for the improvement of the system of medical evaluations and determinations.

(j) After public hearing pursuant to Section 5307.3, the administrative director shall adopt regulations concerning the following issues:

(1) Standards governing the timeframes within which medical evaluations shall be prepared and submitted by agreed and qualified medical evaluators. Except as provided in this subdivision, the timeframe for initial medical evaluations to be prepared and submitted shall be no more than 30 days after the evaluator has seen the employee or otherwise commenced the medical evaluation procedure. *The administrative director shall develop timeframes governing availability of qualified medical evaluators for unrepresented employees under Sections 4061 and 4062. These timeframes shall give the employee the right to the addition of a new evaluator to his or her panel, selected at random, for each evaluator not available to see the employee within a specified period of time, but shall also permit the employee to waive this right for a specified period of time thereafter.* The administrative director shall adopt regulations governing the provision of extensions of the 30-day period in *both of the following* cases: (A) where the evaluator has not received test results or consulting physician's evaluations in time to meet the 30-day deadline; and, (B) to extend the 30-day period by not more than 15 days when the failure to meet the 30-day deadline was for good cause. For

purposes of this subdivision, "good cause" means *any of the following*:

(i) medical emergencies of the evaluator or evaluator's family;

(ii) death in the evaluator's family; or

(iii) natural disasters or other community catastrophes that interrupt the operation of the evaluator's business.

(2) Procedures to be followed by all physicians in evaluating the existence and extent of permanent impairment and limitations resulting from an injury. In order to produce complete, accurate, uniform, and replicable evaluations, the procedures shall require that an evaluation of anatomical loss, functional loss, and the presence of physical complaints be supported, to the extent feasible, by ~~medical~~ *objective* findings *in support of medical evidence* based on standardized examinations and testing techniques generally accepted by the medical community. *Objective findings in support of medical evidence are verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength, and palpable muscle spasm. Objective findings do not include physical findings or subjective responses to physical examinations that are not reproducible, measurable, or observable.*

(3) Procedures governing the determination of any disputed medical issues.

(4) Procedures to be used in determining the compensability of psychiatric injury. The procedures shall be in accordance with Section 3208.3 and shall require that the diagnosis of a mental disorder be expressed using the terminology and criteria of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised, or the terminology and diagnostic criteria of other psychiatric diagnostic manuals generally approved and accepted nationally by practitioners in the field of psychiatric medicine.

(5) Guidelines for the range of time normally required to perform the following:

(A) A medical-legal evaluation that has not been defined and valued pursuant to Section 5307.6. The guidelines shall establish minimum times for patient contact in the conduct of the evaluations, and shall be consistent with regulations adopted pursuant to Section 5307.6.

(B) Any treatment procedures that have not been defined and valued pursuant to Section 5307.1.

(C) Any other evaluation procedure requested by the Insurance Commissioner or deemed appropriate by the administrative director.

(6) Any additional medical or professional standards that a medical evaluator shall meet as a condition of appointment, reappointment, or maintenance in the status of a medical evaluator.

(k) *(1)* Except as provided in this subdivision, the administrative director may, in his or her discretion, suspend or terminate the privilege of a physician to serve as a qualified medical evaluator if the administrative director, after hearing pursuant to subdivision (l), determines, based on substantial evidence, that a qualified medical evaluator:

~~(1)~~ *(A)* Has violated any material statutory or administrative duty.

~~(2)~~ *(B)* Has failed to follow the medical procedures or qualifications established *by the administrative director* pursuant to paragraph (2), (3), (4), or (5) of subdivision (j).

~~(3)~~ *(C)* Has failed to comply with the timeframe standards established *by the administrative director* pursuant to subdivision (j).

~~(4)~~ *(D)* Has failed to meet the requirements of subdivision (b) or (c).

~~(5)~~ *(E)* Has prepared medical-legal evaluations that fail to meet the minimum standards for those reports established by the administrative director or the appeals board.

~~(6)~~ *(F)* Has made material misrepresentations or false statements in an application for appointment or reappointment as a qualified medical evaluator.

(2) No hearing shall be required prior to the suspension or termination of a physician's privilege to serve as a qualified medical evaluator when the physician has done either of the following:

(A) Failed to timely pay the fee required pursuant to subdivision (n).

(B) Had his or her license to practice in California suspended by the relevant licensing authority so as to preclude practice, or had the license revoked or terminated by the licensing authority.

(l) The administrative director shall cite the qualified medical evaluator for a violation listed in subdivision (k) and shall set a hearing on the alleged violation within 30 days of service of the citation on the qualified medical evaluator. In addition to the authority to terminate or suspend the qualified medical evaluator upon finding a violation listed in subdivision (k), the administrative director may, in his or her discretion, place a qualified medical evaluator on probation subject to appropriate conditions, including ordering continuing education or training. The administrative director shall report to the appropriate licensing board the name of any qualified medical evaluator who is disciplined pursuant to this subdivision.

(m) The administrative director shall terminate from the list of medical evaluators any physician where licensure has been terminated by the relevant licensing board, or who has been convicted of a misdemeanor or felony related to the conduct of his or her medical practice, or of a crime of moral turpitude. The administrative director shall suspend or terminate as a medical evaluator any physician who has been suspended or placed on probation by the relevant licensing board. If a physician is suspended or terminated as a qualified medical evaluator under this subdivision, a report prepared by the physician that is not complete, signed, and furnished to one or more of the parties prior to the date of conviction or action of the licensing board, whichever is earlier, shall not be admissible in any proceeding before the appeals board nor shall there be any liability for payment for the report and any expense incurred by the physician in connection with the report.

(n) Each qualified medical evaluator shall pay a fee, as determined by the administrative director, for appointment or reappointment. *Any qualified medical evaluator appointed prior to January 1, 1993, shall also pay the same fee as specified in accordance with this subdivision.* These fees shall be based on a sliding scale as established by the administrative director. All revenues from fees paid under this subdivision shall be deposited into the Workers' Compensation Administration Revolving Fund and are available for expenditure upon appropriation by the Legislature, and shall not be used by any other department or

agency or for any purpose other than administration of the programs of the Division of Workers' Compensation related to the provision of medical treatment to injured employees.

(o) An evaluator may not request or accept any compensation or other thing of value from any source that does or could create a conflict with his or her duties as an evaluator under this code. The administrative director, after consultation with the Commission on Health and Safety and Workers' Compensation, shall adopt regulations to implement this subdivision.

SEC. 6. Section 3201.5 of the Labor Code is amended to read:

3201.5. (a) Except as provided in subdivisions (b) and (c), the Department of Industrial Relations and the courts of this state shall recognize as valid and binding any provision in a collective bargaining agreement between a ~~private~~ employer or groups of employers ~~engaged in construction, construction maintenance, or activities limited to rock, sand, gravel, cement and asphalt operations, heavy duty mechanics, surveying, and construction inspection~~ and a union that is the recognized or certified exclusive bargaining representative that establishes any of the following:

(1) An alternative dispute resolution system governing disputes between employees and employers or their insurers that supplements or replaces all or part of those dispute resolution processes contained in this division, including, but not limited to, mediation and arbitration. Any system of arbitration shall provide that the decision of the arbiter or board of arbitration is subject to review by the appeals board in the same manner as provided for reconsideration of a final order, decision, or award made and filed by a workers' compensation administrative law judge pursuant to the procedures set forth in Article 1 (commencing with Section 5900) of Chapter 7 of Part 4 of Division 4, and the court of appeals pursuant to the procedures set forth in Article 2 (commencing with Section 5950) of Chapter 7 of Part 4 of Division 4, governing orders, decisions, or awards of the appeals board. The findings of fact, award, order, or decision of the arbitrator shall have the same force and effect as an award, order, or decision of a workers' compensation administrative law judge. Any provision for arbitration established pursuant to this section shall not be subject to Sections 5270, 5270.5, 5271, 5272, 5273, 5275, and 5277.

(2) The use of an agreed list of providers of medical treatment that may be the exclusive source of all medical treatment provided under this division.

(3) The use of an agreed, limited list of qualified medical evaluators and agreed medical evaluators that may be the exclusive source of qualified medical evaluators and agreed medical evaluators under this division.

(4) Joint labor management safety committees.

(5) A light-duty, modified job or return-to-work program.

(6) A vocational rehabilitation or retraining program utilizing an agreed list of providers of rehabilitation services that may be the exclusive source of providers of rehabilitation services under this division.

(b) Nothing in this section shall allow a collective bargaining agreement that diminishes the entitlement of an employee to compensation payments for total or partial disability, temporary disability, vocational rehabilitation, or medical treatment fully paid by the employer as otherwise provided in this division. The portion of any agreement that violates this subdivision shall be declared null and void.

(c) Subdivision (a) shall apply only to the following:

(1) An employer developing or projecting an annual workers' compensation insurance premium, in California, of two hundred fifty thousand dollars ($250,000) or more, or any employer that paid an annual workers' compensation insurance premium, in California, of two hundred fifty thousand dollars ($250,000) in at least one of the previous three years.

(2) Groups of employers engaged in a workers' compensation safety group complying with Sections 11656.6 and 11656.7 of the Insurance Code, and established pursuant to a joint labor management safety committee or committees, that develops or projects annual workers' compensation insurance premiums of two million dollars ($2,000,000) or more.

(3) Employers or groups of employers that are self-insured in compliance with Section 3700 that would have projected annual workers' compensation costs that meet the requirements of, and that meet the other requirements of, paragraph (1) in the case of employers, or paragraph (2) in the case of groups of employers.

(4) Employers covered by an owner or general contractor provided wrap-up insurance policy applicable to a single construction site that develops workers' compensation insurance premiums of two million dollars ($2,000,000) or more with respect to those employees covered by that wrap-up insurance policy.

(d) Employers and labor representatives who meet the eligibility requirements of this section shall be issued a letter by the administrative director advising each employer and labor representative that, based upon the review of all documents and materials submitted as required by the administrative director, each has met the eligibility requirements of this section.

(e) The premium rate for a policy of insurance issued pursuant to this section shall not be subject to the requirements of Section 11732 or 11732.5 of the Insurance Code.

(f) No employer may establish or continue a program established under this section until it has provided the administrative director with all of the following:

(1) Upon its original application and whenever it is renegotiated thereafter, a copy of the collective bargaining agreement and the approximate number of employees who will be covered thereby.

(2) Upon its original application and annually thereafter, a valid and active license where that license is required by law as a condition of doing business in the state ~~within the industries set forth in subdivision (a) of Section 3201.5.~~

(3) Upon its original application and annually thereafter, a statement signed under penalty of perjury, that no action has been taken by any administrative agency or court of the United States to invalidate the collective bargaining agreement.

(4) The name, address, and telephone number of the contact person of the employer.

(5) Any other information that the administrative director deems necessary to further the purposes of this section.

(g) No collective bargaining representative may establish or continue to participate in a program established under this section unless all of the following requirements are met:

(1) Upon its original application and annually thereafter, it has provided to the administrative director a copy of its most recent LM-2 or LM-3 filing with the United States Department of Labor, along with a statement, signed under penalty of perjury, that the document is a true and correct copy.

(2) It has provided to the administrative director the name, address, and telephone number of the contact person or persons of the collective bargaining representative or representatives.

(h) Commencing July 1, 1995, and annually thereafter, the Division of Workers' Compensation shall report to the Director of the Department of Industrial Relations the number of collective bargaining agreements received and the number of employees covered by these agreements.

(i) By June 30, 1996, and annually thereafter, the Administrative Director of the Division of Workers' Compensation shall prepare and notify Members of the Legislature that a report authorized by this section is available upon request. The report based upon aggregate data shall include the following:

(1) Person hours and payroll covered by agreements filed.

(2) The number of claims filed.

(3) The average cost per claim shall be reported by cost components whenever practicable.

(4) The number of litigated claims, including the number of claims
submitted to mediation, the appeals board, or the court of appeal.

(5) The number of contested claims resolved prior to arbitration.

(6) The projected incurred costs and actual costs of claims.

(7) Safety history.

(8) ~~The number of workers participating in vocational rehabilitation.~~

~~(9)~~ The number of workers participating in light-duty programs.

The division shall have the authority to require those employers and groups of employers listed in subdivision (c) to provide the data listed above.

(j) The data obtained by the administrative director pursuant to this section shall be confidential and not subject to public disclosure under any law of this state. However, the Division of Workers' Compensation shall create derivative works pursuant to subdivisions (h) and (i) based on the collective bargaining agreements and data. Those derivative works shall not be confidential, but shall be public. On a monthly basis the administrative director shall make available an updated list of employers and unions entering into collective bargaining agreements containing provisions authorized by this section.

SEC. 7. Labor Code Section 3201.7 is repealed.

~~3201.7. (a) Except as provided in subdivision (b), the Department of Industrial Relations and the courts of this state shall recognize as valid and binding any labor management agreement that meets all of the following requirements:~~

~~(1) The labor management agreement has been negotiated separate and apart from any collective bargaining agreement covering affected employees.~~

~~(2) The labor management agreement is restricted to the establishment of the terms and conditions necessary to implement this section.~~

~~(3) The labor management agreement has been negotiated in accordance with the authorization of the administrative director pursuant to subdivision (d), between an employer or groups of employers and a union that is the recognized or certified exclusive bargaining representative that establishes any of the following:~~

~~(A) An alternative dispute resolution system governing disputes between employees and employers or their insurers that supplements or replaces all or part of those dispute resolution processes contained in this division, including, but not limited to, mediation and arbitration. Any system of arbitration shall provide that the decision of the arbiter or board of arbitration is subject to review by the appeals board in the same manner as provided for reconsideration of a final order, decision, or award made and filed by a workers' compensation administrative law judge pursuant to the procedures set forth in Article 1 (commencing with Section 5900) of Chapter 7 of Part 4 of Division 4, and the court of appeals pursuant to the procedures set forth in Article 2 (commencing with Section 5950) of Chapter 7 of Part 4 of Division 4, governing orders, decisions, or awards of the appeals board. The findings of fact, award, order, or decision of the arbitrator shall have the same force and effect as an award, order, or decision of a workers' compensation administrative law judge. Any provision for arbitration established pursuant to this section shall not be subject to Sections 5270, 5270.5, 5271, 5272, 5273, 5275, and 5277.~~

~~(B) The use of an agreed list of providers of medical treatment that may be the exclusive source of all medical treatment provided under this division.~~

~~(C)The use of an agreed, limited list of qualified medical evaluators and agreed medical evaluators that may be the exclusive source of qualified medical evaluators and agreed medical evaluators under this division.~~

~~(D) Joint labor management safety committees.~~

~~(E) A light duty, modified job, or return to work program.~~

~~(F) A vocational rehabilitation or retraining program utilizing an agreed list of providers of rehabilitation services that may be the exclusive source of providers of rehabilitation services under this division.~~

~~(b) Nothing in this section shall allow a labor management agreement that diminishes the entitlement of an employee to compensation payments for total or partial disability, temporary disability, vocational rehabilitation, or medical treatment fully paid by the employer as otherwise provided in this division; nor shall any agreement authorized by this section deny to any employee the right to representation by counsel at all stages during the alternative dispute resolution process. The portion of any agreement that violates this subdivision shall be declared null and void.~~

~~(c) Subdivision (a) shall apply only to the following:~~

~~(1) An employer developing or projecting an annual workers' compensation insurance premium, in California, of fifty thousand dollars ($50,000) or more, and employing at least 50 employees, or any employer that paid an annual workers' compensation insurance premium, in California, of fifty thousand dollars ($50,000), and employing at least 50 employees in at least one of the previous three years.~~

~~(2) Groups of employers engaged in a workers' compensation safety group complying with Sections 11656.6 and 11656.7 of the~~

~~Insurance Code, and established pursuant to a joint labor management safety committee or committees, that develops or projects annual workers' compensation insurance premiums of five hundred thousand dollars ($500,000) or more.~~

~~(3) Employers or groups of employers, including cities and counties, that are self-insured in compliance with Section 3700 that would have projected annual workers' compensation costs that meet the requirements of, and that meet the other requirements of, paragraph (1) in the case of employers, or paragraph (2) in the case of groups of employers.~~

~~(d) Any recognized or certified exclusive bargaining representative in an industry not covered by Section 3201.5, may file a petition with the administrative director seeking permission to negotiate with an employer or group of employers to enter into a labor-management agreement pursuant to this section. The petition shall specify the bargaining unit or units to be included, the names of the employers or groups of employers, and shall be accompanied by proof of the labor union's status as the exclusive bargaining representative. The current collective bargaining agreement or agreements shall be attached to the petition. The petition shall be in the form designated by the administrative director. Upon receipt of the petition, the administrative director shall promptly verify the petitioner's status as the exclusive bargaining representative.~~

~~If the petition satisfies the requirements set forth in this subdivision, the administrative director shall issue a letter advising each employer and labor representative of their eligibility to enter into negotiations, for a period not to exceed one year, for the purpose of reaching agreement on a labor-management agreement pursuant to this section. The parties may jointly request, and shall be granted, by the administrative director, an additional one-year period to negotiate an agreement.~~

~~(e) No employer may establish or continue a program established under this section until it has provided the administrative director with all of the following:~~

~~(1) Upon its original application and whenever it is renegotiated thereafter, a copy of the labor-management agreement and the approximate number of employees who will be covered thereby.~~

~~(2) Upon its original application and annually thereafter, a statement signed under penalty of perjury, that no action has been taken by any administrative agency or court of the United States to invalidate the labor-management agreement.~~

~~(3) The name, address, and telephone number of the contact person of the employer.~~

~~(4) Any other information that the administrative director deems necessary to further the purposes of this section.~~

~~(f) No collective bargaining representative may establish or continue to participate in a program established under this section unless all of the following requirements are met:~~

~~(1) Upon its original application and annually thereafter, it has provided to the administrative director a copy of its most recent LM-2 or LM-3 filing with the United States Department of Labor, where such filing is required by law, along with a statement, signed under penalty of perjury, that the document is a true and correct copy.~~

~~(2) It has provided to the administrative director the name, address, and telephone number of the contact person or persons of the collective bargaining representative or representatives.~~

~~(g) Commencing July 1, 2005, and annually thereafter, the Division of Workers' Compensation shall report to the Director of Industrial Relations the number of labor-management agreements received and the number of employees covered by these agreements.~~

~~(h) By June 30, 2006, and annually thereafter, the administrative director shall prepare and notify Members of the Legislature that a report authorized by this section is available upon request. The report based upon aggregate data shall include the following:~~

~~(1) Person hours and payroll covered by agreements filed.~~

~~(2) The number of claims filed.~~

~~(3) The average cost per claim shall be reported by cost components whenever practicable.~~

~~(4) The number of litigated claims, including the number of claims submitted to mediation, the appeals board, or the court of appeal.~~

~~(5) The number of contested claims resolved prior to arbitration.~~

~~(6) The projected incurred costs and actual costs of claims.~~

~~(7) Safety history.~~

~~(8) The number of workers participating in vocational rehabilitation.~~

~~(9) The number of workers participating in light-duty programs.~~

~~(10) Overall worker satisfaction.~~

~~The division shall have the authority to require employers and groups of employers participating in labor-management agreements pursuant to this section to provide the data listed above.~~

~~(i) The data obtained by the administrative director pursuant to this section shall be confidential and not subject to public disclosure under any law of this state. However, the Division of Workers' Compensation shall create derivative works pursuant to subdivisions (f) and (g) based on the labor-management agreements and data. Those derivative works shall not be confidential, but shall be public. On a monthly basis, the administrative director shall make available an updated list of employers and unions entering into labor-management agreements authorized by this section.~~

SEC. 8. Section 3208 of the Labor Code is amended to read:

3208. "Injury" includes any injury or disease arising out of the employment *that is certified by a physician using medical evidence based on objective findings, as defined in paragraph (2) of subdivision (j) of Section 139.2*, including injuries to artificial members, dentures, hearing aids, eyeglasses, and medical braces of all types ~~; provided, however, that~~. *However,* eyeglasses and hearing aids will not be replaced, repaired, or otherwise compensated for, unless injury to them is incident to an injury causing disability.

SEC. 9. Section 3208.1 of the Labor Code is amended to read:

3208.1. *(a)* An injury may be either ~~: (a) "specific,"~~ *of the following:*

(1) "Specific" and thus occurring as the result of one incident or exposure ~~which~~ *that* causes disability or need for medical treatment ~~; or (b) "cumulative,"~~ .

(2) "Cumulative" and thus occurring as repetitive mentally or physically traumatic activities extending over a period of time, the combined effect of which causes any disability or need for medical treatment. ~~The~~

(b) The date of a cumulative injury shall be the date determined under Section 5412.

(c) In order to establish that a cumulative injury is compensable, an employee shall demonstrate by a preponderance of medical evidence, that the injury was predominantly caused by actual activities of employment.

(d) In order to establish that a specific injury is compensable, an employee shall demonstrate by a preponderance of medical evidence that the injury has contributed at least 10 percent to the cause of the disability or death when compared to all causes of the death or disability in total.

SEC. 10. Section 3600 of the Labor Code is amended to read:

3600. (a) Liability for the compensation *and any other liability under law* provided by this division *and Division 1*, in lieu of any other liability whatsoever to any person except as otherwise specifically provided in Sections 3602, 3706, and 4558, shall, without regard to negligence, exist against an employer, *including* for any injury sustained by his or her employees arising out of and in the course of the employment and for the death of any employee if the injury proximately causes death, in those cases where the following conditions of compensation ~~concur~~ *occur*:

(1) Where, at the time of the injury, both the employer and the employee are subject to the compensation provisions of this division.

(2) Where, at the time of the injury, the employee is performing service growing out of and incidental to his or her employment and is acting within the course of his or her employment.

(3) Where the injury, *as described in Section 3208*, is ~~proximately~~ caused by the employment either with or without negligence.

(4) Where the injury is not caused by the intoxication, by alcohol or the unlawful use of a controlled substance, of the injured employee. As used in this paragraph, "controlled substance" shall have the same meaning as prescribed in Section 11007 of the Health and Safety Code.

(5) Where the injury is not intentionally self-inflicted.

(6) Where the employee has not willfully and deliberately caused his or her own death.

(7) Where the injury does not arise out of an altercation in which the injured employee is the initial physical aggressor.

(8) Where the injury is not caused by the commission of a felony, or a crime which is punishable as specified in subdivision (b) of Section 17 of the Penal Code, by the injured employee, for which he or she has been convicted.

(9) Where the injury does not arise out of voluntary participation in any off-duty recreational, social, or athletic activity not constituting part of the employee's work-related duties, except where these activities are a reasonable expectancy of, or are expressly or impliedly required by, the employment. The administrative director shall promulgate reasonable rules and regulations requiring employers to post and keep posted in a conspicuous place or places a notice advising employees of the provisions of this subdivision. Failure of the employer to post the notice shall not constitute an expression of intent to waive the provisions of this subdivision.

(10) Except for psychiatric injuries governed by subdivision (e) of Section 3208.3, where the claim for compensation is filed after notice of termination or layoff, including voluntary layoff, and the claim is for an injury occurring prior to the time of notice of termination or layoff, no compensation shall be paid unless the employee demonstrates by a preponderance of the evidence that one or more of the following conditions apply:

(A) The employer has notice of the injury, as provided under Chapter 2 (commencing with Section 5400), prior to the notice of termination or layoff.

(B) The employee's medical records, existing prior to the notice of termination or layoff, contain evidence of the injury.

(C) The date of injury, as specified in Section 5411, is subsequent to the date of the notice of termination or layoff, but prior to the effective date of the termination or layoff.

(D) The date of injury, as specified in Section 5412, is subsequent to the date of the notice of termination or layoff. For purposes of this paragraph, an employee provided notice pursuant to Sections 44948.5, 44949, 44951, 44955, 44955.6, 72411, 87740, and 87743 of the Education Code shall be considered to have been provided a notice of termination or layoff only upon a district' s final decision not to reemploy that person.

A notice of termination or layoff that is not followed within 60 days by that termination or layoff shall not be subject to the provisions of this paragraph, and this paragraph shall not apply until receipt of a later notice of termination or layoff. The issuance of frequent notices of termination or layoff to an employee shall be considered a bad faith personnel action and shall make this paragraph inapplicable to the employee.

(b) Where an employee, or his or her dependents, receives the compensation provided by this division and secures a judgment for, or settlement of, civil damages pursuant to those specific exemptions to the employee's exclusive remedy set forth in subdivision (b) of Section 3602 and Section 4558, the compensation paid under this division shall be credited against the judgment or settlement, and the employer shall be relieved from the obligation to pay further compensation to, or on behalf of, the employee or his or her dependents up to the net amount of the judgment or settlement received by the employee or his or her heirs, or that portion of the judgment as has been satisfied.

Section 4060 of the Labor Code is amended to read:

4060. (a) This section shall *only* apply to disputes over the compensability of any injury. This section shall not apply where injury to any part or parts of the body is accepted as compensable by the employer.

(b) Neither the employer nor the employee shall be liable for any comprehensive medical-legal evaluation performed by other than the treating physician either in whole or in part on behalf of the employee prior to the filing of a claim form and prior to the time the claim is denied or becomes presumptively compensable under Section 5402. However, reports of treating physicians shall be admissible.

(c) If a medical evaluation is required to determine compensability at any time after the period specified in subdivision (b), and the employee is represented by an attorney, each party may select a qualified medical evaluator to conduct a comprehensive medical-legal evaluation. Neither party may obtain more than one comprehensive medical-legal report, provided, however, that any party may obtain additional reports at their own expense. The

parties may, at any time, agree on one medical evaluator to evaluate the issues in dispute.

(d) If a medical evaluation is required to determine compensability at any time after the period specified in subdivision (b), and the employee is not represented by an attorney, the employer shall not seek agreement with the employee on a physician to prepare a comprehensive medical-legal evaluation. The employee may select a qualified medical evaluator to prepare a comprehensive medical-legal evaluation. The division shall assist unrepresented employees, and shall make available to them the list of medical evaluators compiled under Section 139.2. Neither party may obtain more than one comprehensive medical-legal report, provided, however, that any party may obtain additional reports at their own expense. If an employee has received a comprehensive medical-legal evaluation under this subdivision, and he or she later becomes represented by an attorney, he or she shall not be entitled to an additional evaluation at the employer's expense.

(e) Evaluations performed under this section shall ~~not~~ be limited to the issue of the compensability of the injury ~~, but shall address all medical issues in dispute~~

SEC. 11. Section 4061 of the Labor Code is amended to read:

4061. (a) Together with the last payment of temporary disability indemnity, the employer shall, in a form prescribed by the administrative director pursuant to Section 138.4, provide the employee one of the following:

(1) Notice either that no permanent disability indemnity will be paid because the employer alleges the employee has no permanent impairment or limitations resulting from the injury or notice of the amount of permanent disability indemnity determined by the employer to be payable. The notice shall include information concerning how the employee may obtain a formal medical evaluation pursuant to subdivision (c) if he or she disagrees with the position taken by the employer. The notice shall be accompanied by the form prescribed by the administrative director for requesting assignment of a panel of qualified medical evaluators, unless the employee is represented by an attorney. If the employer determines permanent disability indemnity is payable, the employer shall advise the employee of the amount determined payable and the basis on which the determination was made and whether there is need for continuing medical care.

(2) Notice that permanent disability indemnity may be or is payable, but that the amount cannot be determined because the employee's medical condition is not yet permanent and stationary. The notice shall advise the employee that his or her medical condition will be monitored until it is permanent and stationary, at which time the necessary evaluation will be performed to determine the existence and extent of permanent impairment and limitations for the purpose of rating permanent disability and to determine the need for continuing medical care, or at which time the employer will advise the employee of the amount of permanent disability indemnity the employer has determined to be payable. If an employee is provided notice pursuant to this paragraph and the employer later takes the position that the employee has no permanent impairment or limitations resulting from the injury, or later determines permanent disability indemnity is payable, the employer shall in either event, within 14 days of the determination to take either position, provide the employee with the notice specified in paragraph (1).

(b) Each notice required by subdivision (a) shall describe the administrative procedures available to the injured employee and advise the employee of his or her right to consult an information and assistance officer or an attorney. It shall contain the following language:

"Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits."

(c) If the parties do not agree to a permanent disability rating based on the treating physician's evaluation or the assessment of need for continuing medical care, and the employee is represented by an attorney, the employer shall seek agreement with the employee on a physician to prepare a comprehensive medical evaluation of the employee's permanent impairment and limitations and any need for continuing medical care resulting from the injury. If no agreement is reached within 10 days, or any additional time not to exceed 20 days agreed to by the parties, the parties may not later select an agreed medical evaluator. Evaluations of an employee's permanent impairment and limitations obtained prior to the period to reach agreement shall not be admissible in any proceeding before the appeals board. After the period to reach agreement has expired, either party may select a qualified medical evaluator to conduct the comprehensive medical evaluation. Neither party may obtain more than one comprehensive medical-legal report, provided, however, that any party may obtain additional reports at their own expense.

(d) *(1)* If the parties do not agree to a permanent disability rating based on the treating physician's evaluation, and if the employee is not represented by an attorney, the employer shall not seek agreement with the employee on a physician to prepare an additional medical evaluation. ~~The employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators.~~ The *employer shall immediately request assignment of a panel of three qualified medical evaluators from the medical director and notify the employee of the request on a form prescribed by the administrator director. A copy of the treating physician's evaluation shall be included with the request. Within 30 days of receipt of notice of the assignment of the panel from the medical director*, the employee shall select a physician from the panel to prepare a medical evaluation of the employee's permanent impairment and limitations and any need for continuing medical care resulting from the ~~injury. For~~ *injury. If a comprehensive medical legal valuation has been prepared by the treating physician, and no good cause exists, as defined in subdivision (g), for the failure of the employee to select a qualified medical evaluator within the 30-day time period set forth in this subdivision, or, if no assignment of a panel has been made by the medical director within the timeframes required by subdivision (h) of Section 139.2 and the employee has failed to select a qualified medical evaluator within 45 days of receipt of the notice from the*

employer that a panel has been requested, issues relating to the existence or extent of permanent impairment and limitations or the need for continuing medical care resulting from the injury may be the subject of a declaration of readiness to proceed.

(2) For injuries occurring on or after January 1, 2003, ~~except as provided in subdivision (b) of Section 4064,~~ the report of the qualified medical evaluator and the reports of the treating physician or physicians shall be the only admissible reports and shall be the only reports obtained by the employee or the employer on the issues subject to this section.

(e) If an employee obtains a qualified medical evaluator from a panel pursuant to subdivision (d) or pursuant to subdivision (b) of Section 4062, and thereafter becomes represented by an attorney and obtains an additional qualified medical evaluator, the employer shall have a corresponding right to secure an additional qualified medical evaluator.

(f) The represented employee shall be responsible for making an appointment with an agreed medical evaluator.

(g) The unrepresented employee shall ~~be responsible for making~~ *make* an appointment with a qualified medical evaluator selected from a panel of three qualified medical evaluators *within 30 days of receipt of the notice of the assignment of the panel from the medical director. If a comprehensive medical-legal evaluation has been completed by the treating physician, and if no good cause exists for the failure of the employee to schedule the evaluation, issues relating to the existence or extent of permanent impairment and limitations or the need for continuing medical care resulting from the injury may be the subject of a declaration of readiness to proceed.* The evaluator shall give the employee, at the appointment, a brief opportunity to ask questions concerning the evaluation process and the evaluator's background. The unrepresented employee shall then participate in the evaluation as requested by the evaluator unless the employee has good cause to discontinue the evaluation. For purposes of this subdivision, "good cause *to discontinue the evaluation*" shall include evidence that the evaluator is biased against the employee because of his or her race, sex, national origin, religion, or sexual preference or evidence that the evaluator has requested the employee to submit to an unnecessary medical examination or procedure. If the unrepresented employee declines to proceed with the evaluation, he or she shall have the right to a new panel of three qualified medical evaluators from which to select one to prepare a comprehensive medical evaluation. If the appeals board subsequently determines that the employee did not have good cause to not proceed with the evaluation, the cost of the evaluation shall be deducted from any award the employee obtains.

(h) Upon selection or assignment pursuant to subdivision (c) or (d), the medical evaluator shall perform a comprehensive ~~medical~~ *medical-legal* evaluation according to the procedures ~~promulgated~~ *adopted* by the administrative director under paragraphs (2) and (3) of subdivision (j) of Section 139.2 and summarize the ~~medical~~ findings on a form prescribed by the administrative director. The comprehensive ~~medical~~ *medical-legal* evaluation shall address all contested ~~medical~~ issues *regarding the employee's permanent impairment and limitations and any need for continuing medical care* arising from all injuries reported on one or more claim forms prior to the date of the employee's initial appointment with the medical evaluator. If, after a comprehensive ~~medical~~ *medical-legal* evaluation is prepared, the employer or the employee subsequently objects to any new ~~medical~~ issue *regarding the employee's permanent impairment and limitations and any need for continuing medical care* , the parties, to the extent possible, shall utilize the same medical evaluator who prepared the previous evaluation to resolve the medical dispute.

(i) Except as provided in Section 139.3, the medical evaluator may obtain consultations from other physicians who have treated the employee for the injury whose expertise is necessary to provide a complete and accurate evaluation.

(j) The qualified medical evaluator who has evaluated an unrepresented employee shall serve the comprehensive medical evaluation and the summary form on the employee, employer, and the administrative director. The unrepresented employee or the employer may submit the treating physician's evaluation for the calculation of a permanent disability rating. Within 20 days of receipt of the comprehensive medical evaluation, the administrative director shall calculate the permanent disability rating according to Section 4660 and serve the rating on the employee and employer.

(k) Any comprehensive medical evaluation concerning an unrepresented employee which indicates that part or all of an employee's permanent impairment or limitations may be subject to apportionment pursuant to Sections 4663 or 4750 shall first be submitted by the administrative director to a workers' compensation judge who may refer the report back to the qualified medical evaluator for correction or clarification if the judge determines the proposed apportionment is inconsistent with the law.

(l) Within 30 days of receipt of the rating, if the employee is unrepresented, the employee or employer may request that the administrative director reconsider the recommended rating or obtain additional information from the treating physician or medical evaluator to address issues not addressed or not completely addressed in the original comprehensive medical evaluation or not prepared in accord with the procedures promulgated under paragraph (2) or (3) of subdivision (j) of Section 139.2. This request shall be in writing, shall specify the reasons the rating should be reconsidered, and shall be served on the other party. If the administrative director finds the comprehensive medical evaluation is not complete or not in compliance with the required procedures, the administrative director shall return the report to the treating physician or qualified medical evaluator for appropriate action as the administrative director instructs. Upon receipt of the treating physician's or qualified medical evaluator's final comprehensive medical evaluation and summary form, the administrative director shall recalculate the permanent disability rating according to Section 4660 and serve the rating, the comprehensive medical evaluation, and the summary form on the employee and employer.

(m) If a comprehensive medical evaluation from the treating physician or an agreed medical evaluator or a qualified medical evaluator selected from a three-member panel resolves any issue so as to require an employer to provide compensation, the employer shall commence the payment of compensation or promptly commence proceedings before the appeals board to resolve the

dispute. If the employee and employer agree to a stipulated findings and award as provided under Section 5702 or to compromise and release the claim under Chapter 2 (commencing with Section 5000) of Part 3, or if the employee wishes to commute the award under Chapter 3 (commencing with Section 5100) of Part 3, the appeals board shall first determine whether the agreement or commutation is in the best interests of the employee and whether the proper procedures have been followed in determining the permanent disability rating. The administrative director shall promulgate a form to notify the employee, at the time of service of any rating under this section, of the options specified in this subdivision, the potential advantages and disadvantages of each option, and the procedure for disputing the rating.

(n) No issue relating to the existence or extent of permanent impairment and limitations or the need for continuing medical care resulting from the injury may be the subject of a declaration of readiness to proceed unless there has first been a medical evaluation by a treating physician or an agreed or qualified medical evaluator. With the exception of an evaluation or evaluations prepared by the treating physician or physicians, no evaluation of permanent impairment and limitations or need for continuing medical care resulting from the injury shall be obtained prior to service of the comprehensive medical evaluation on the employee and employer if the employee is unrepresented, or prior to the attempt to select an agreed medical evaluator if the employee is represented. Evaluations obtained in violation of this prohibition shall not be admissible in any proceeding before the appeals board. However, the testimony, records, and reports offered by the treating physician or physicians who treated the employee for the injury and comprehensive medical evaluations prepared by a qualified medical evaluator selected by an unrepresented employee from a three-member panel shall be admissible.

SEC. 12. Section 4062 of the Labor Code is repealed.

~~4062. (a) If either the employee or employer objects to a medical determination made by the treating physician concerning the permanent and stationary status of the employee's medical condition, the employee's preclusion or likely preclusion to engage in his or her usual occupation, the extent and scope of medical treatment, the existence of new and further disability, or any other medical issues not covered by Section 4060 or 4061, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney. Employer objections to the treating physician's recommendation for spinal surgery shall be subject to subdivision (b), and after denial of the physician's recommendation, in accordance with Section 4610. These time limits may be extended for good cause or by mutual agreement. If the employee is represented by an attorney, the parties shall seek agreement with the other party on a physician, who need not be a qualified medical evaluator, to prepare a report resolving the disputed issue. If no agreement is reached within 10 days, or any additional time not to exceed 20 days agreed upon by the parties, the parties may not later select an agreed medical evaluator. Evaluations obtained prior to the period to reach agreement shall not be admissible in any proceeding before the appeals board. After the period to reach agreement has expired, the objecting party may select a qualified medical evaluator to conduct the comprehensive medical evaluation. Neither party may obtain more than one comprehensive medical legal report, provided, however, that any party may obtain additional reports at their own expense. The nonobjecting party may continue to rely on the treating physician's report or may select a qualified medical evaluator to conduct an additional evaluation.~~

~~(b) The employer may object to a report of the treating physician recommending that spinal surgery be performed within 10 days of the receipt of the report. If the employee is represented by an attorney, the parties shall seek agreement with the other party on a California licensed board-certified or board-eligible orthopedic surgeon or neurosurgeon to prepare a second opinion report resolving the disputed surgical recommendation. If no agreement is reached within 10 days, or if the employee is not represented by an attorney, an orthopedic surgeon or neurosurgeon shall be randomly selected by the administrative director to prepare a second opinion report resolving the disputed surgical recommendation. Examinations shall be scheduled on an expedited basis. The second opinion report shall be served on the parties within 45 days of receipt of the treating physician's report. If the second opinion report recommends surgery, the employer shall authorize the surgery. If the second opinion report does not recommend surgery, the employer shall file declaration of readiness to proceed. The employer shall not be liable for medical treatment costs for the disputed surgical procedure, whether through a lien filed with the appeals board or as a self-procured medical expense, or for periods of temporary disability resulting from the surgery, if the disputed surgical procedure is performed prior to the completion of the second opinion process required by this subdivision.~~

~~(c) The second opinion physician shall not have any material professional, familial, or financial affiliation, as determined by the administrative director, with any of the following:~~

~~(1) The employer, his or her workers' compensation insurer, third-party claims administrator, or other entity contracted to provide utilization review services pursuant to Section 4610.~~

~~(2) Any officer, director, or employee of the employer's health care provider, workers' compensation insurer, or third-party claims administrator.~~

~~(3) A physician, the physician's medical group, or the independent practice association involved in the health care service in dispute.~~

~~(4) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the employer's health care provider, workers' compensation insurer, or third-party claims administrator, would be provided.~~

~~(5) The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the employee or his or her treating physician whose treatment is under review, or the alternative therapy, if any, recommended by the employer or other entity.~~

~~(6) The employee or the employee's immediate family.~~

~~(d) If the employee is not represented by an attorney, the employer shall not seek agreement with the employee on a physician to prepare the comprehensive medical evaluation. Except in cases where the treating physician's recommendation that spinal surgery be performed pursuant to subdivision (b), the employer shall immediately provide the employee with a form prescribed by the medical director with~~

~~which to request assignment of a panel of three qualified medical evaluators. The employee shall select a physician from the panel to prepare a comprehensive medical evaluation. For injuries occurring on or after January 1, 2003, except as provided in subdivision (b) of Section 4064, the evaluation of the qualified medical evaluator selected from a panel of three and the reports of the treating physician or physicians shall be the only admissible reports and shall be the only reports obtained by the employee or employer on issues subject to this section in a case involving an unrepresented employee.~~

~~(e) Upon completing a determination of the disputed medical issue, the physician selected under subdivision (a) or (d) to perform the medical evaluation shall summarize the medical findings on a form prescribed by the administrative director and shall serve the formal medical evaluation and the summary form on the employee and the employer. The medical evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee's initial appointment with the medical evaluator. If, after a medical evaluation is prepared, the employer or the employee subsequently objects to any new medical issue, the parties, to the extent possible, shall utilize the same medical evaluator who prepared the previous evaluation to resolve the medical dispute.~~

~~(f) No disputed medical issue specified in subdivision (a) may be the subject of a declaration of readiness to proceed unless there has first been an evaluation by the treating physician or an agreed or qualified medical evaluator.~~

~~(g) With the exception of a report or reports prepared by the treating physician or physicians, no report determining disputed medical issues set forth in subdivision (a) shall be obtained prior to the expiration of the period to reach agreement on the selection of an agreed medical evaluator under subdivision (a). Reports obtained in violation of this prohibition shall not be admissible in any proceeding before the appeals board. However, the testimony, records, and reports offered by the treating physician or physicians who treated the employee for the injury shall be admissible.~~

~~(h) This section shall remain in effect only until January 1, 2007, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2007, deletes or extends that date.~~

~~Section 4062.01 is added to the Labor Code, to read:~~

SEC. 13. Section 4062 of the Labor Code is added:

4062. (a) If either the employee or employer objects to a determination made by the treating physician concerning the employee's preclusion or likely preclusion to engage in his or her usual occupation, or the existence of new and further disability, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney. These time limits may be extended for good cause or by mutual agreement. If the employee is represented by an attorney, the parties shall seek agreement with the other party on a physician, who need not be a qualified medical evaluator, to prepare a report resolving the disputed issue. If no agreement is reached within 10 days, or any additional time not to exceed 20 days agreed upon by the parties, the parties may not later select an agreed medical evaluator. Evaluations obtained prior to the period to reach agreement shall not be admissible in any proceeding before the appeals board. After the period to reach agreement has expired, the objecting party may select a qualified medical evaluator to conduct the comprehensive medical evaluation. Neither party may obtain more than one comprehensive medical-legal report, provided, however, that any party may obtain additional reports at their own expense. The nonobjecting party may continue to rely on the treating physician's report or may select a qualified medical evaluator to conduct an additional evaluation.

(b) (1) If the employee is not represented by an attorney, the employer shall not seek agreement with the employee on a physician to prepare the comprehensive medical evaluation. The employer shall immediately request assignment of a panel of three qualified medical evaluators from the medical director and notify the employee of the request on a form prescribed by the administrative director. A copy of the treating physician's evaluation shall be included with the request. Within 30 days of receipt of notice of the assignment of the panel from the medical director, the employee shall select a physician from the panel to prepare a comprehensive medical evaluation. If no good cause exists, as defined in subdivision (g) of Section 4061, for the failure of the employee to select a qualified medical evaluator within the 30-day time period set forth in this subdivision, or, if no assignment of a panel has been made by the medical director within the timeframes required by subdivision (h) of Section 139.2 and the employee has failed to select a qualified medical evaluator within 45 days of receipt of the notice from the employer that a panel has been requested, issues relating to the existence or extent of permanent impairment and limitations or the need for continuing medical care resulting from the injury may be the subject of a declaration of readiness to proceed.

(2) For injuries occurring on or after January 1, 2003, the evaluation of the qualified medical evaluator selected from a panel of three and the reports of the treating physician or physicians shall be the only admissible reports and shall be the only reports obtained by the employee or employer on issues subject to this section in a case involving an unrepresented employee.

(c) With the exception of a report or reports prepared by the treating physician or physicians, no report determining disputed issues set forth in subdivision (a) shall be obtained prior to the expiration of the period to reach agreement on the selection of an agreed medical evaluator under subdivision (a). Reports obtained in violation of this prohibition shall not be admissible in any proceeding before the appeals board. However, the testimony, records, and reports offered by the treating physician or physicians who treated the employee for the injury shall be admissible.

SEC. 14. Section 4062.01 of the Labor Code is repealed.

~~4062.01. (a) If either the employee or employer objects to a medical determination made by the treating physician concerning the permanent and stationary status of the employee's medical condition, the employee's preclusion or likely preclusion to engage in his or her usual occupation, the extent and scope of medical treatment, the existence of new and further disability, or any other medical issues not covered by Section 4060 or 4061, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30~~

~~days of receipt of the report if the employee is not represented by an attorney. These time limits may be extended for good cause or by mutual agreement. If the employee is represented by an attorney, the parties shall seek agreement with the other party on a physician, who need not be a qualified medical evaluator, to prepare a report resolving the disputed issue. If no agreement is reached within 10 days, or any additional time not to exceed 20 days agreed upon by the parties, the parties may not later select an agreed medical evaluator. Evaluations obtained prior to the period to reach agreement shall not be admissible in any proceeding before the appeals board. After the period to reach agreement has expired, the objecting party may select a qualified medical evaluator to conduct the comprehensive medical evaluation. Neither party may obtain more than one comprehensive medical-legal report, provided, however, that any party may obtain additional reports at their own expense. The nonobjecting party may continue to rely on the treating physician's report or may select a qualified medical evaluator to conduct an additional evaluation.~~

~~(b) If the employee is not represented by an attorney, the employer shall not seek agreement with the employee on a physician to prepare the comprehensive medical evaluation. The employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators. The employee shall select a physician from the panel to prepare a comprehensive medical evaluation. The evaluation of the qualified medical evaluator selected from a panel of three and the reports of the treating physician or physicians shall be the only admissible reports and shall be the only reports obtained by the employee or employer on issues subject to this section in a case involving an unrepresented employee.~~

~~(c) Upon completing a determination of the disputed medical issue, the physician selected under subdivision (a) or (b) to perform the medical evaluation shall summarize the medical findings on a form prescribed by the administrative director and shall serve the formal medical evaluation and the summary form on the employee and the employer. The medical evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee's initial appointment with the medical evaluator. If, after a medical evaluation is prepared, the employer or the employee subsequently objects to any new medical issue, the parties, to the extent possible, shall utilize the same medical evaluator who prepared the previous evaluation to resolve the medical dispute.~~

~~(d) No disputed medical issue specified in subdivision (a) may be the subject of a declaration of readiness to proceed unless there has first been an evaluation by the treating physician or an agreed or qualified medical evaluator.~~

~~(e) With the exception of a report or reports prepared by the treating physician or physicians, no report determining disputed medical issues set forth in subdivision (a) shall be obtained prior to the expiration of the period to reach agreement on the selection of an agreed medical evaluator under subdivision (a). Reports obtained in violation of this prohibition shall not be admissible in any proceeding before the appeals board. However, the testimony, records, and reports offered by the treating physician or physicians who treated the employee for the injury shall be admissible.~~

~~(f) This section shall become operative on January 1, 2007.~~

SEC. 15. Section 4062.9 of the Labor Code is repealed.

~~4062.9. (a) In cases where an additional comprehensive medical evaluation is obtained under Section 4061 or 4062, if the employee has been treated by his or her personal physician, or by is or her personal chiropractor, as defined in Section 4601, who was predesignated prior to the date of injury as provided under Section 4600, the findings of the personal physician or personal chiropractor are presumed to be correct. This presumption is rebuttable and may be controverted by a preponderance of medical opinion indicating a different level of disability. However, the presumption shall not apply where both parties select qualified medical examiners.~~

~~(b) In all cases other than those specified in subdivision (a), regardless of the date of injury, no presumption shall apply to the opinion of any physician on the issue of extent and scope of medical treatment, either prior or subsequent to the issuance of an award.~~

~~(c) The administrative director shall develop, not later than January 1, 2004, and periodically revise as necessary thereafter, educational materials to be used to provide treating physicians and chiropractors with information and training in basic concepts of workers' compensation, the role of the treating physician, the conduct of permanent and stationary evaluations, and report writing.~~

~~(d) The amendment made to this section by SB 228 of the 2003-04 Regular Session shall not constitute good cause to reopen or rescind, alter, or amend any order, decision, or award of the appeals board.~~

SEC. 16. Section 4064 of the Labor Code is amended to read:

4064. (a) The employer shall be liable for the cost of each reasonable and necessary comprehensive medical-legal evaluation obtained by the employee pursuant to Sections 4060, 4061, and 4062. Each comprehensive medical-legal evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms.

(b) ~~For injuries occurring on or after January 1, 2003, if an unrepresented employee obtains an attorney after the evaluation pursuant to subdivision (d) of Section 4061 or subdivision (b) of Section 4062 has been completed, the employee shall be entitled to the same reports at employer expense as an employee who has been represented from the time the dispute arose and those reports shall be admissible in any proceeding before the appeals board.~~

~~(c)~~ Subject to Section 4906, if an employer files an application for adjudication and the employee is unrepresented at the time the application is filed, the employer shall be liable for any attorney's fees incurred by the employee in connection with the application for adjudication.

~~(d)~~

(c) The employer shall not be liable for the cost of any comprehensive ~~medical~~ *medical-legal* evaluations obtained by the employee other than those authorized pursuant to Sections 4060, 4061, and 4062. However, no party is prohibited from obtaining any ~~medical~~ evaluation or consultation at the party's own expense. In no event shall an employer or employee be liable for an evaluation obtained in violation of subdivision (b) of Section 4060. All comprehensive ~~medical~~ *medical-legal* evaluations obtained by any party shall be admissible in any proceeding before the appeals board except as provided in subdivisions (d) and (m) of Section 4061 and subdivisions (b) and (e) of Section 4062.

SEC. 17. Section 4452.5 of the Labor Code is amended to read:

4452.5 As used in this division:

(a) "Permanent total disability" means a permanent disability with a rating of 100 percent permanent disability only.

(b) "Permanent partial disability" means a permanent disability with a rating of less than 100 percent permanent disability.

(c) "Permanent and stationary" means that, based on objective findings of medical evidence, no further material improvement would reasonably be expected from additional medical treatment or the passage of time.

SEC. 18. Section 4453.1 of the Labor Code is added to the Labor Code to read:

4453.1 *Notwithstanding any other provision of law, no inmate of a correctional institution shall be eligible for temporary disability or permanent disability. The sole remedy for care and redress shall be in-custody medical treatment as provided by the county or state penal institution. The state, county or municipality in which an injury occurs shall have the responsibility to provide medical care to the inmate while confined. Medical care provided while in custody shall be considered the sole remedy for an injury that occurs while in custody.*

SEC. 19. Section 4600 of the Labor Code is amended to read:

4600. *(a)* Medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including orthotic and prosthetic devices and services, that is reasonably required to cure ~~or~~ *and* relieve from the effects of the injury shall be provided by the employer. In the case of his or her neglect or refusal ~~seasonably~~ *reasonably* to do so, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing treatment. ~~After~~

(b) (1) As used in this division and notwithstanding any other provision of law, medical treatment that is reasonably required to cure and relieve the injured worker from the effects of his or her injury means treatment consistent with the guidelines promulgated by the administrative director pursuant to Section 5307.27, or any guidelines meeting the requirements of Section 5307.27.

(2) Paragraph (1) shall apply to all treatment requested on or after July 1, 2004, including treatment for injuries sustained prior to that date.

(c) After 30 days from the date the injury is reported, the employee may be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area *, only if the selection of the physician or facility is mutually agreed to by the employer* . However, if an employee has notified his or her employer in writing prior to the date of injury that he or she has a personal physician *and the employer has agreed to the choice* , the employee shall have the right to be treated by that physician from the date of injury~~. If an employee requests a change of physician pursuant to Section 4601, the request may be made at any time after the injury, and the alternative physician, chiropractor, or acupuncturist shall be provided within five days of the request as required by Section 4601.~~ For the purpose of this section, "personal physician" means the employee's regular physician and surgeon, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, who has previously directed the medical treatment of the employee, and who retains the employee's medical records, including his or her medical history. ~~Where~~

(d) (1) Where at the request of the employer, the employer's insurer, the administrative director, the appeals board, or a workers' compensation judge, the employee submits to examination by a physician, he or she shall be entitled to receive in addition to all other benefits herein provided all reasonable expenses of transportation, meals, and lodging incident to reporting for the examination, together with one day of temporary disability indemnity for each day of wages lost in submitting to the examination. ~~Regardless~~

(2) Regardless of the date of injury, "reasonable expenses of transportation" includes mileage fees from the employee's home to the place of the examination and back at the rate of twenty-one cents ($0.21) a mile or the mileage rate adopted by the Director of the Department of Personnel Administration pursuant to Section 19820 of the Government Code, whichever is higher, plus any bridge tolls. The mileage and tolls shall be paid to the employee at the time he or she is given notification of the time and place of the examination. ~~Where~~

(e) Where at the request of the employer, the employer's insurer, the administrative director, the appeals board, a workers' compensation judge, an employee submits to examination by a physician and the employee does not proficiently speak or understand the English language, he or she shall be entitled to the services of a qualified interpreter in accordance with conditions and a fee schedule prescribed by the administrative director. These services shall be provided by the employer. For purposes of this section, "qualified interpreter" means a language interpreter certified, or deemed certified, pursuant to Article 8 (commencing with Section 11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or Section 68566 of, the Government Code.

(f) An employer may also discharge his obligations under this section by contracting with a health care organization authorized pursuant to Section 4600.5 to provide medical treatment pursuant to Sections 4600.3 or 4600.31.

SEC. 20. Section 4600.2 of the Labor Code is amended to read:

4600.2. (a) ~~Notwithstanding~~ *In accordance with subdivision (b) of* Section 4600, when a self-insured employer, group of self-insured employers, insurer of an employer, or group of insurers contracts with a pharmacy, group of pharmacies, or pharmacy benefit network to provide medicines and medical supplies required by this article to be provided to injured employees, those injured employees that are subject to the contract shall be provided medicines and medical supplies in the manner prescribed in the contract for as long as medicines or medical supplies are reasonably required to cure ~~or~~ *and* relieve the injured employee from the effects of the injury *as prescribed in Section 4600* .

(b) Nothing in this section shall affect the ability of employee-selected physicians to continue to prescribe and have the employer provide medicines and medical supplies that the physicians deem reasonably required to cure ~~or~~ *and* relieve the injured employee from the effects of the injury *as prescribed in Section 4600* .

(c) Each contract described in subdivision (a) shall comply with standards adopted by the administrative director. In adopting those standards, the administrative director shall seek to reduce

pharmaceutical costs and may consult any relevant studies or practices in other states. The standards shall provide for access to a pharmacy within a reasonable geographic distance from an injured employee's residence.

SEC. 21. Section 4600.3 of the Labor Code is repealed.

~~4600.3. (a) (1) Notwithstanding Section 4600, when a self-insured employer, group of self insured employers, or the insurer of an employer contracts with a health care organization certified pursuant to Section 4600.5 for health care services required by this article to be provided to injured employees, those employees who are subject to the contract shall receive medical services in the manner prescribed in the contract, providing that the employee may choose to be treated by a personal physician, personal chiropractor, or personal acupuncturist that he or she has designated prior to the injury, in which case the employee shall not be treated by the health care organization. Every employee shall be given an affirmative choice at the time of employment and at least annually thereafter to designate or change the designation of a health care organization or a personal physician, personal chiropractor, or personal acupuncturist. The choice shall be memorialized in writing and maintained in the employee's personnel records. The employee who has designated a personal physician, personal chiropractor, or personal acupuncturist may change their designated caregiver at any time prior to the injury. Any employee who fails to designate a personal physician, personal chiropractor, or personal acupuncturist shall be treated by the health care organization selected by the employer. If the health care organization offered by the employer is the workers' compensation insurer that covers the employee or is an entity that controls or is controlled by that insurer, as defined by Section 1215 of the Insurance Code, this information shall be included in the notice of contract with a health care organization.~~

~~(2) Each contract described in paragraph (1) shall comply with the certification standards provided in Section 4600.5, and shall provide all medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including artificial members, that is reasonably required to cure or relieve the effects of the injury, as required by this division, without any payment by the employee of deductibles, copayments, or any share of the premium. However, an employee may receive immediate emergency medical treatment that is compensable from a medical service or health care provider who is not a member of the health care organization.~~

~~(3) Insured employers, a group of self-insured employers, or self-insured employers who contract with a health care organization for medical services shall give notice to employees of eligible medical service providers and any other information regarding the contract and manner of receiving medical services as the administrative director may prescribe. Employees shall be duly notified that if they choose to receive care from the health care organization they must receive treatment for all occupational injuries and illnesses as prescribed by this section.~~

~~(b) Notwithstanding subdivision (a), no employer which is required to bargain with an exclusive or certified bargaining agent which represents employees of the employer in accordance with state or federal employer-employee relations law shall contract with a health care organization for purposes of Section 4600.5 with regard to employees whom the bargaining agent is recognized or certified to represent for collective bargaining purposes pursuant to state or federal employer-employee relations law unless authorized to do so by mutual agreement between the bargaining agent and the employer. If the collective bargaining agreement is subject to the National Labor Relations Act, the employer may contract with a health care organization for purposes of Section 4600.5 at any time when the employer and bargaining agent have bargained to impasse to the extent required by federal law.~~

~~(c) (1) When an employee is not receiving or is not eligible to receive health care coverage for nonoccupational injuries or illnesses provided by the employer, if 90 days from the date the injury is reported the employee who has been receiving treatment from a health care organization or his or her physician, chiropractor, acupuncturist, or other agent notifies his or her employer in writing that he or she desires to stop treatment by the health care organization, he or she shall have the right to be treated by a physician, chiropractor, or acupuncturist or at a facility of his or her own choosing within a reasonable geographic area.~~

~~(2) When an employee is receiving or is eligible to receive health care coverage for nonoccupational injuries or illnesses provided by the employer, and has agreed to receive care for occupational injuries and illnesses from a health care organization provided by the employer, the employee may be treated for occupational injuries and diseases by a physician, chiropractor, or acupuncturist of his or her own choice or at a facility of his or her own choice within a reasonable geographic area if the employee or his or her physician, chiropractor, acupuncturist, or other agent notifies his or her employer in writing only after 180 days from the date the injury was reported, or upon the date of contract renewal or open enrollment of the health care organization, whichever occurs first, but in no case until 90 days from the date the injury was reported.~~

~~(3) For purposes of this subdivision, an employer shall be deemed to provide health care coverage for nonoccupational injuries and illnesses if the employer pays more than one-half the costs of the coverage, or if the plan is established pursuant to collective bargaining. (d) An employee and employer may agree to other forms of therapy pursuant to Section 3209.7.~~

~~(e) An employee enrolled in a health care organization shall have the right to no less than one change of physician on request, and shall be given a choice of physicians affiliated with the health care organization. The health care organization shall provide the employee a choice of participating physicians within five days of receiving a request. In addition, the employee shall have the right to a second opinion from a participating physician on a matter pertaining to diagnosis or treatment from a participating physician.~~

~~(f) Nothing in this section or Section 4600.5 shall be construed to prohibit a self-insured employer, a group of self-insured employers, or insurer from engaging in any activities permitted by Section 4600.~~

~~(g) Notwithstanding subdivision (c), in the event that the employer, group of employers, or the employer's workers' compensation insurer no longer contracts with the health care organization that has been treating an injured employee, the employee may continue treatment provided or arranged by the health care organization. If the employee does not choose to~~

~~continue treatment by the health care organization, the employer may control the employee's treatment for 30 days from the date the injury was reported. After that period, the employee may be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area.~~

SEC. 22. Section 4600.3 is added to the Labor Code, to read:

4600.3. (a) This section shall only apply to employees who are eligible to receive health care coverage for nonoccupational injuries or illnesses provided in whole or part by their employer.

(b) (1) A self-insured employer, group of self-insured employers, or the insurer of an employer may contract with a health care organization certified pursuant to Section 4600.5 for health care services required by this article to be provided to injured employees, and those employees who are subject to the contract shall receive medical services in the manner prescribed in the contract. An employer may contract for health care coverage for nonoccupational injuries or illnesses with the same entity that provides medical treatment required by this article. The employee shall receive medical treatment in the manner prescribed in the contract.

(2) The employee may choose to be treated by a personal physician prior to the injury, in which case, the physician shall be chosen from the list of medical providers authorized by the health care organization.

(3) Each contract described in paragraph (1) shall comply with the certification standards provided in Section 4600.5, and shall provide all medically necessary treatment consistent with the Knox-Keene Health Care Service Plan of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), which shall be presumed to be treatment reasonably required to cure and relieve the injured worker from the effects of his or her injury. This presumption affects the burden of proof. Notwithstanding any other provision of law, all services provided by the health care organization, including those provided pursuant to the organization's utilization review and independent medical review, shall also be presumed to be treatment reasonably required to cure and relieve the injured worker from the effects of his or her injury. This presumption affects the burden of proof.

(4) Notwithstanding any other provision of this section, an employee may receive immediate emergency medical treatment that is compensable from a medical service or health care provider who is not a member of the health care organization.

(5) Notwithstanding any provision of this article, no employee shall be required to pay any deductible, copayment, or any share of the premium for medical treatment provided for occupational injuries or illnesses pursuant to a contract entered into pursuant to this section.

(c) An employee enrolled in a health care organization shall have the right to no less than one change of physician on request and for this purpose shall choose from physicians affiliated with the health care organization. The health care organization shall provide the employee with a choice of these participating physicians within five days of receiving a request. In addition, the employee shall have the right to a second opinion from a participating physician on a matter pertaining to diagnosis or treatment from a participating physician.

(d) Nothing in this section or Section 4600.5 shall be construed to prohibit a self-insured employer, a group of self-insured employers, or insurer from engaging in any activities permitted by Section 4600.

(e) Notwithstanding subdivision (c), in the event that the employer, group of employers, or the employer's workers' compensation insurer no longer contracts with the health care organization that has been treating an injured employee, the employee may continue treatment provided or arranged by the health care organization for an additional 90 days, at the employer's expense.

SEC. 23. *Section 4600.31 is added to the Labor Code, to read:*

4600.31. (a) (1) A self-insured employer, group of self-insured employers, or the insurer of an employer may contract with a health care organization certified pursuant to Section 4600.5 for health care services required by this article to be provided to injured employees, and those employees who are subject to the contract shall receive medical services in the manner prescribed in the contract. The employee shall receive medical treatment in the manner prescribed in the contract that is consistent with Section 4600.

(2) The employee may choose to be treated by a personal physician prior to the injury, in which case, the physician shall be chosen from the list of medical providers authorized by the health care organization.

(3) Notwithstanding any other provision of this section, an employee may receive immediate emergency medical treatment that is compensable from a medical service or health care provider who is not a member of the health care organization.

(4) Notwithstanding any provision of this article, no employee shall be required to pay any deductible, copayment, or any share of the premium for medical treatment provided for occupational injuries or illnesses pursuant to a contract entered into pursuant to this section.

(b) An employee enrolled in a health care organization shall have the right to no less than one change of physician on request, and for this purpose shall choose from physicians affiliated with the health care organization. The health care organization shall provide the employee with a choice of these participating physicians within five days of receiving a request. In addition, the employee shall have the right to a second opinion from a participating physician on a matter pertaining to diagnosis or treatment from a participating physician.

(c) Nothing in this section or Section 4600.5 shall be construed to prohibit a self-insured employer, a group of self-insured employers, or insurer from engaging in any activities permitted by Section 4600.

(d) Notwithstanding subdivision (c), in the event that the employer, group of employers, or the employer's workers' compensation insurer no longer contracts with the health care organization that has been treating an injured employee, the employee may continue treatment provided or arranged by the health care organization for an additional 90 days, at the employer's expense.

SEC. 24. Section 4600.35 of the Labor Code is repealed.

~~4600.35. Any entity seeking to reimburse health care providers for health care services rendered to injured workers on a capitated, or per person per month basis, shall be licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).~~

SEC. 25. Section 4600.5 of the Labor Code is repealed.

~~4600.5. (a) Any health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act, a disability insurer licensed by the Department of Insurance, or any entity, including, but not limited to, workers' compensation insurers and third-party administrators authorized by the administrative director under subdivision (e), may make written application to the administrative director to become certified as a health care organization to provide health care to injured employees for injuries and diseases compensable under this article.~~

~~(b) Each application for certification shall be accompanied by a reasonable fee prescribed by the administrative director, sufficient to cover the actual cost of processing the application. A certificate is valid for the period that the director may prescribe unless sooner revoked or suspended.~~

~~(c) If the health care organization is a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act, and has provided the Managed Care Unit of the Division of Workers' Compensation with the necessary documentation to comply with this subdivision, that organization shall be deemed to be a health care organization able to provide health care pursuant to Section 4600.3, without further application duplicating the documentation already filed with the Department of Managed Health Care. These plans shall be required to remain in good standing with the Department of Managed Health Care, and shall meet the following additional requirements:~~

~~(1) Proposes to provide all medical and health care services that may be required by this article.~~

~~(2) Provides a program involving cooperative efforts by the employees, the employer, and the health plan to promote workplace health and safety, consultative and other services, and early return to work for injured employees.~~

~~(3) Proposes a timely and accurate method to meet the requirements set forth by the administrative director for all carriers of workers' compensation coverage to report necessary information regarding medical and health care service cost and utilization, rates of return to work, average time in medical treatment, and other measures as determined by the administrative director to enable the director to determine the effectiveness of the plan.~~

~~(4) Agrees to provide the administrative director with information, reports, and records prepared and submitted to the Department of Managed Health Care in compliance with the Knox-Keene Health Care Service Plan Act, relating to financial solvency, provider accessibility, peer review, utilization review, and quality assurance, upon request, if the administrative director determines the information is necessary to verify that the plan is providing medical treatment to injured employees in compliance with the requirements of this code.~~

~~Disclosure of peer review proceedings and records to the administrative director shall not alter the status of the proceedings or records as privileged and confidential communications pursuant to Sections 1370 and 1370.1 of the Health and Safety Code.~~

~~(5) Demonstrates the capability to provide occupational medicine and related disciplines.~~

~~(6) Complies with any other requirement the administrative director determines is necessary to provide medical services to injured employees consistent with the intent of this article, including, but not limited to, a written patient grievance policy.~~

~~(d) If the health care organization is a disability insurer licensed by the Department of Insurance, and is in compliance with subdivision (d) of Sections 10133 and 10133.5 of the Insurance Code, the administrative director shall certify the organization to provide health care pursuant to Section 4600.3 if the director finds that the plan is in good standing with the Department of Insurance and meets the following additional requirements:~~

~~(1) Proposes to provide all medical and health care services that may be required by this article.~~

~~(2) Provides a program involving cooperative efforts by the employees, the employer, and the health plan to promote workplace health and safety, consultative and other services, and early return to work for injured employees.~~

~~(3) Proposes a timely and accurate method to meet the requirements set forth by the administrative director for all carriers of workers' compensation coverage to report necessary information regarding medical and health care service cost and utilization, rates of return to work, average time in medical treatment, and other measures as determined by the administrative director to enable the director to determine the effectiveness of the plan.~~

~~(4) Agrees to provide the administrative director with information, reports, and records prepared and submitted to the Department of Insurance in compliance with the Insurance Code relating to financial solvency, provider accessibility, peer review, utilization review, and quality assurance, upon request, if the administrative director determines the information is necessary to verify that the plan is providing medical treatment to injured employees consistent with the intent of this article.~~

~~Disclosure of peer review proceedings and records to the administrative director shall not alter the status of the proceedings or records as privileged and confidential communications pursuant to subdivision (d) of Section 10133 of the Insurance Code.~~

~~(5) Demonstrates the capability to provide occupational medicine and related disciplines.~~

~~(6) Complies with any other requirement the administrative director determines is necessary to provide medical services to injured employees consistent with the intent of this article, including, but not limited to, a written patient grievance policy.~~

~~(e) If the health care organization is a workers' compensation insurer, third-party administrator, or any other entity that the administrative director determines meets the requirements of Section 4600.6, the administrative director shall certify the organization to provide health care pursuant to Section 4600.3 if the director finds that it meets the following additional requirements:~~

~~(1) Proposes to provide all medical and health care services that may be required by this article.~~

~~(2) Provides a program involving cooperative efforts by the employees, the employer, and the health plan to promote workplace~~

health and safety, consultative and other services, and early return to work for injured employees.

(3) Proposes a timely and accurate method to meet the requirements set forth by the administrative director for all carriers of workers' compensation coverage to report necessary information regarding medical and health care service cost and utilization, rates of return to work, average time in medical treatment, and other measures as determined by the administrative director to enable the director to determine the effectiveness of the plan.

(4) Agrees to provide the administrative director with information, reports, and records relating to provider accessibility, peer review, utilization review, quality assurance, advertising, disclosure, medical and financial audits, and grievance systems, upon request, if the administrative director determines the information is necessary to verify that the plan is providing medical treatment to injured employees consistent with the intent of this article. Disclosure of peer review proceedings and records to the administrative director shall not alter the status of the proceedings or records as privileged and confidential communications pursuant to subdivision (d) of Section 10133 of the Insurance Code.

(5) Demonstrates the capability to provide occupational medicine and related disciplines.

(6) Complies with any other requirement the administrative director determines is necessary to provide medical services to injured employees consistent with the intent of this article, including, but not limited to, a written patient grievance policy.

(7) Complies with the following requirements:

(A) An organization certified by the administrative director under this subdivision may not provide or undertake to arrange for the provision of health care to employees, or to pay for or to reimburse any part of the cost of that health care in return for a prepaid or periodic charge paid by or on behalf of those employees.

(B) Every organization certified under this subdivision shall operate on a fee-for-service basis. As used in this section, fee for service refers to the situation where the amount of reimbursement paid by the employer to the organization or providers of health care is determined by the amount and type of health care rendered by the organization or provider of health care.

(C) An organization certified under this subdivision is prohibited from assuming risk.

(f) (1) A workers' compensation health care provider organization authorized by the Department of Corporations on December 31, 1997, shall be eligible for certification as a health care organization under subdivision (e).

(2) An entity that had, on December 31, 1997, submitted an application with the Commissioner of Corporations under Part 3.2 (commencing with Section 5150) shall be considered an applicant for certification under subdivision (e) and shall be entitled to priority in consideration of its application. The Commissioner of Corporations shall provide complete files for all pending applications to the administrative director on or before January 31, 1998.

(g) The provisions of this section shall not affect the confidentiality or admission in evidence of a claimant's medical treatment records.

(h) Charges for services arranged for or provided by health care service plans certified by this section and that are paid on a per-enrollee periodic charge basis shall not be subject to the schedules adopted by the administrative director pursuant to Section 5307.1.

(i) Nothing in this section shall be construed to expand or constrict any requirements imposed by law on a health care service plan or insurer when operating as other than a health care organization pursuant to this section.

(j) In consultation with interested parties, including the Department of Corporations and the Department of Insurance, the administrative director shall adopt rules necessary to carry out this section.

(k) The administrative director shall refuse to certify or may revoke or suspend the certification of any health care organization under this section if the director finds that:

(1) The plan for providing medical treatment fails to meet the requirements of this section.

(2) A health care service plan licensed by the Department of Managed Health Care, a workers' compensation health care provider organization authorized by the Department of Corporations, or a carrier licensed by the Department of Insurance is not in good standing with its licensing agency.

(3) Services under the plan are not being provided in accordance with the terms of a certified plan.

(l) (1) When an injured employee requests chiropractic treatment or work-related injuries, the health care organization shall provide the injured worker with access to the services of a chiropractor pursuant to guidelines for chiropractic care established by paragraph (2). Within five working days of the employee's request to see a chiropractor, the health care organization and any person or entity who directs the kind or manner of health care services for the plan shall refer an injured employee to an affiliated chiropractor for work-related injuries that are within the guidelines for chiropractic care established by paragraph (2). Chiropractic care rendered in accordance with guidelines for chiropractic care established pursuant to paragraph (2) shall be provided by duly licensed chiropractors affiliated with the plan.

(2) The health care organization shall establish guidelines for chiropractic care in consultation with affiliated chiropractors who are participants in the health care organization's utilization review process for chiropractic care, which may include qualified medical evaluators knowledgeable in the treatment of chiropractic conditions. The guidelines for chiropractic care shall, at a minimum, explicitly require the referral of any injured employee who so requests to an affiliated chiropractor for the evaluation or treatment, or both, of neuromusculoskeletal conditions.

(3) Whenever a dispute concerning the appropriateness or necessity of chiropractic care for work-related injuries arises, the dispute shall be resolved by the health care organization's utilization review process for chiropractic care in accordance with the health care organization's guidelines for chiropractic care established by paragraph (2). Chiropractic utilization review for work-related injuries shall be conducted in accordance with the health care organization's approved quality assurance standards and utilization review process for chiropractic care. Chiropractors affiliated with the plan shall have access to the health care organization's provider

~~appeals process and, in the case of chiropractic care for work-related injuries, the review shall include review by a chiropractor affiliated with the health care organization, as determined by the health care organization.~~

~~(4) The health care organization shall inform employees of the procedures for processing and resolving grievances, including those related to chiropractic care, including the location and telephone number where grievances may be submitted.~~

~~(5) All guidelines for chiropractic care and utilization review shall be consistent with the standards of this code that require care to cure or relieve the effects of the industrial injury.~~

~~(m) Individually identifiable medical information on patients submitted to the division shall not be subject to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).~~

~~(n) (1) When an injured employee requests acupuncture treatment for work-related injuries, the health care organization shall provide the injured worker with access to the services of an acupuncturist pursuant to guidelines for acupuncture care established by paragraph (2). Within five working days of the employee's request to see an acupuncturist, the health care organization and any person or entity who directs the kind or manner of health care services for the plan shall refer an injured employee to an affiliated acupuncturist for work-related injuries that are within the guidelines for acupuncture care established by paragraph (2). Acupuncture care rendered in accordance with guidelines for acupuncture care established pursuant to paragraph (2) shall be provided by duly licensed acupuncturists affiliated with the plan.~~

~~(2) The health care organization shall establish guidelines for acupuncture care in consultation with affiliated acupuncturists who are participants in the health care organization's utilization review process for acupuncture care, which may include qualified medical evaluators. The guidelines for acupuncture care shall, at a minimum, explicitly require the referral of any injured employee who so requests to an affiliated acupuncturist for the evaluation or treatment, or both, of neuromusculoskeletal conditions.~~

~~(3) Whenever a dispute concerning the appropriateness or necessity of acupuncture care for work-related injuries arises, the dispute shall be resolved by the health care organization's utilization review process for acupuncture care in accordance with the health care organization's guidelines for acupuncture care established by paragraph (2). Acupuncture utilization review for work-related injuries shall be conducted in accordance with the health care organization's approved quality assurance standards and utilization review process for acupuncture care. Acupuncturists affiliated with the plan shall have access to the health care organization's provider appeals process and, in the case of acupuncture care for work-related injuries, the review shall include review by an acupuncturist affiliated with the health care organization, as determined by the health care organization.~~

~~(4) The health care organization shall inform employees of the procedures for processing and resolving grievances, including those related to acupuncture care, including the location and telephone number where grievances may be submitted.~~

~~(5) All guidelines for acupuncture care and utilization review shall be consistent with the standards of this code that require care to cure or relieve the effects of the industrial injury.~~

SEC. 26. Section 4600.5 is added to the Labor Code, to read:

4600.5. (a) Any health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act, a disability insurer licensed by the Department of Insurance, or any entity, including, but not limited to, workers' compensation insurers and third-party administrators authorized by the administrative director under subdivision (e), may make written application to the administrative director to become certified as a health care organization to provide health care to injured employees for injuries and diseases compensable under this article. The administrative director shall establish a process for the timely review of applications.

(b) Each application for certification shall be accompanied by a reasonable fee prescribed by the administrative director, sufficient to cover the actual cost of processing the application. A certificate is valid for the period that the administrative director may prescribe, unless sooner revoked or suspended.

(c) If the health care organization is a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act, and has provided the Managed Care Unit of the Division of Workers' Compensation with the necessary documentation to comply with this subdivision, that organization shall be deemed to be a health care organization able to provide health care pursuant to Section 4600.3, without further application duplicating the documentation already filed with the Department of Managed Health Care. These plans shall be required to remain in good standing with the Department of Managed Health Care, and shall meet all of the requirements the administrative director deems necessary.

(d) If the health care organization is a disability insurer licensed by the Department of Insurance, and is in compliance with subdivision (d) of Sections 10133 and 10133.5 of the Insurance Code, the administrative director shall certify the organization to provide health care pursuant to Section 4600.3 if the administrative director finds that the plan is in good standing with the Department of Insurance and meets all of the requirements the administrative director deems necessary.

(e) If the health care organization is a workers' compensation insurer, third-party administrator, or any other entity that the administrative director determines meets the requirements of this section, the administrative director shall certify the organization to provide health care pursuant to this article.

(f) Charges for services arranged for or provided by health care service plans certified by this section and that are paid on a per-enrollee-periodic-charge basis shall not be subject to the schedules adopted by the administrative director pursuant to Section 5307.1.

(g) Nothing in this section shall be construed to expand or constrict any requirements imposed by law on a health care service plan or insurer when operating as other than a health care organization pursuant to this section.

(h) In consultation with interested parties, including the Department of Corporations and the Department of Insurance, the administrative director shall adopt rules necessary to carry out this section.

(i) The administrative director shall refuse to certify or may revoke or suspend the certification of any health care organization under this section if the director finds that any of the following circumstances exist:

(1) The plan for providing medical treatment fails to meet the requirements of this section.

(2) A health care service plan licensed by the Department of Managed Health Care, a workers' compensation health care provider organization authorized by the Department of Corporations, or a carrier licensed by the Department of Insurance is not in good standing with its licensing agency.

(3) Services under the plan are not being provided in accordance with the terms of a certified plan.

(j) When an injured employee requests chiropractic treatment for work-related injuries, the health care organization shall provide the injured worker with access to the services of a chiropractor. Chiropractic care rendered in accordance with guidelines for chiropractic care shall be provided by duly licensed chiropractors affiliated with the plan.

(k) When an injured employee requests acupuncture treatment for what the treating physician agrees are work-related injuries, the health care organization shall provide the injured worker with access to the services of an acupuncturist. Acupuncture care rendered in accordance with guidelines for acupuncture care shall be provided by duly licensed acupuncturists affiliated with the plan.

SEC. 27. Section 4600.6 of the Labor Code is repealed.

~~4600.6. Any workers' compensation insurer, third-party administrator, or other entity seeking certification as a health care organization under subdivision (e) of Section 4600.5 shall be subject to the following rules and procedures:~~

~~(a) Each application for authorization as an organization under subdivision (e) of Section 4600.5 shall be verified by an authorized representative of the applicant and shall be in a form prescribed by the administrative director. The application shall be accompanied by the prescribed fee and shall set forth or be accompanied by each and all of the following:~~

~~(1) The basic organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents and all amendments thereto.~~

~~(2) A copy of the bylaws, rules, and regulations, or similar documents regulating the conduct of the internal affairs of the applicant.~~

~~(3) A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, which shall include, among others, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers, each shareholder with over 5 percent interest in the case of a corporation, and all partners or members in the case of a partnership or association, and each person who has loaned funds to the applicant for the operation of its business.~~

~~(4) A copy of any contract made, or to be made, between the applicant and any provider of health care, or persons listed in paragraph (3), or any other person or organization agreeing to perform an administrative function or service for the plan. The administrative director by rule may identify contracts excluded from this requirement and make provision for the submission of form contracts. The payment rendered or to be rendered to the provider of health care services shall be deemed confidential information that shall not be divulged by the administrative director, except that the payment may be disclosed and become a public record in any legislative, administrative, or judicial proceeding or inquiry. The organization shall also submit the name and address of each provider employed by, or contracting with, the organization, together with his or her license number.~~

~~(5) A statement describing the organization, its method of providing for health services, and its physical facilities. If applicable, this statement shall include the health care delivery capabilities of the organization, including the number of full-time and part-time physicians under Section 3209.3, the numbers and types of licensed or state-certified health care support staff, the number of hospital beds contracted for, and the arrangements and the methods by which health care will be provided, as defined by the administrative director under Sections 4600.3 and 4600.5.~~

~~(6) A copy of the disclosure forms or materials that are to be issued to employees.~~

~~(7) A copy of the form of the contract that is to be issued to any employer, insurer of an employer, or a group of self-insured employers.~~

~~(8) Financial statements accompanied by a report, certificate, or opinion of an independent certified public accountant. However, the financial statements from public entities or political subdivisions of the state need not include a report, certificate, or opinion by an independent certified public accountant if the financial statement complies with any requirements that may be established by regulation of the administrative director.~~

~~(9) A description of the proposed method of marketing the organization and a copy of any contract made with any person to solicit on behalf of the organization or a copy of the form of agreement used and a list of the contracting parties.~~

~~(10) A statement describing the service area or areas to be served, including the service location for each provider rendering professional services on behalf of the organization and the location of any other organization facilities where required by the administrative director.~~

~~(11) A description of organization grievance procedures to be utilized as required by this part, and a copy of the form specified by paragraph (3) of subdivision (j).~~

~~(12) A description of the procedures and programs for internal review of the quality of health care pursuant to the requirements set forth in this part.~~

~~(13) Evidence of adequate insurance coverage or self-insurance to respond to claims for damages arising out of the furnishing of workers' compensation health care.~~

~~(14) Evidence of adequate insurance coverage or self-insurance to protect against losses of facilities where required by the administrative director.~~

~~(15) Evidence of adequate workers' compensation coverage to protect against claims arising out of work-related injuries that might be brought by the employees and staff of an organization against the organization.~~

~~(16) Evidence of fidelity bonds in such amount as the administrative director prescribes by regulation.~~

~~(17) Other information that the administrative director may reasonably require.~~

~~(b) (1) An organization, solicitor, solicitor firm, or representative may not use or permit the use of any advertising or solicitation that is untrue or misleading, or any form of disclosure that is deceptive. For purposes of this chapter:~~

~~(A) A written or printed statement or item of information shall be deemed untrue if it does not conform to fact in any respect that is or may be significant to an employer or employee, or potential employer or employee.~~

~~(B) A written or printed statement or item of information shall be deemed misleading whether or not it may be literally true, if, in the total context in which the statement is made or the item of information is communicated, the statement or item of information may be understood by a person not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage, or the absence of any exclusion, limitation, or disadvantage of possible significance to an employer or employee, or potential employer or employee.~~

~~(C) A disclosure form shall be deemed to be deceptive if the disclosure form taken as a whole and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge of workers' compensation health care, and the disclosure form therefor, to expect benefits, service charges, or other advantages that the disclosure form does not provide or that the organization issuing that disclosure form does not regularly make available to employees.~~

~~(2) An organization, solicitor, or representative may not use or permit the use of any verbal statement that is untrue, misleading, or deceptive or make any representations about health care offered by the organization or its cost that does not conform to fact. All verbal statements are to be held to the same standards as those for printed matter provided in paragraph (1).~~

~~(c) It is unlawful for any person, including an organization, subject to this part, to represent or imply in any manner that the person or organization has been sponsored, recommended, or approved, or that the person's or organization's abilities or qualifications have in any respect been passed upon, by the administrative director.~~

~~(d) (1) An organization may not publish or distribute, or allow to be published or distributed on its behalf, any advertisement unless (A) a true copy thereof has first been filed with the administrative director, at least 30 days prior to any such use, or any shorter period as the administrative director by rule or order may allow, and (B) the administrative director by notice has not found the advertisement, wholly or in part, to be untrue, misleading, deceptive, or otherwise not in compliance with this part or the rules thereunder, and specified the deficiencies, within the 30 days or any shorter time as the administrative director by rule or order may allow.~~

~~(2) If the administrative director finds that any advertisement of an organization has materially failed to comply with this part or the rules thereunder, the administrative director may, by order, require the organization to publish in the same or similar medium, an approved correction or retraction of any untrue, misleading, or deceptive statement contained in the advertising.~~

~~(3) The administrative director by rule or order may classify organizations and advertisements and exempt certain classes, wholly or in part, either unconditionally or upon specified terms and conditions or for specified periods, from the application of subdivision (a).~~

~~(e) (1) The administrative director shall require the use by each organization of disclosure forms or materials containing any information egarding the health care and terms of the workers' compensation health care contract that the administrative director may require, so as to afford the public, employers, and employees with a full and fair disclosure of the provisions of the contract in readily understood language and in a clearly organized manner. The administrative director may require that the materials be presented in a reasonably uniform manner so as to facilitate comparisons between contracts of the same or other types of organizations. The disclosure form shall describe the health care that is required by the administrative director under Sections 4600.3 and 4600.5, and shall provide that all information be in concise and specific terms, relative to the contract, together with any additional information as may be required by the administrative director, in connection with the organization or contract.~~

~~(2) All organizations, solicitors, and representatives of a workers' compensation health care provider organization shall, when presenting any contract for examination or sale to a prospective employee, provide the employee with a properly completed disclosure form, as prescribed by the administrative director pursuant to this section for each contract so examined or sold.~~

~~(3) In addition to the other disclosures required by this section, every organization and any agent or employee of the organization shall, when representing an organization for examination or sale to any individual purchaser or the representative of a group consisting of 25 or fewer individuals, disclose in writing the ratio of premium cost to health care paid for contracts with individuals and with groups of the same or similar size for the organization's preceding fiscal year. An organization may report that information by geographic area, provided the organization identifies the geographic area and reports information applicable to that geographic area.~~

~~(4) Where the administrative director finds it necessary in the interest of full and fair disclosure, all advertising and other consumer information disseminated by an organization for the purpose of influencing persons to become members of an organization shall contain any supplemental disclosure information that the administrative director may require.~~

~~(f) When the administrative director finds it necessary in the interest of full and fair disclosure, all advertising and other consumer information disseminated by an organization for the purpose of influencing persons to become members of an organization shall contain any supplemental disclosure information that the administrative director may require.~~

~~(g) (1) An organization may not refuse to enter into any contract or may not cancel or decline to renew or reinstate any contract because of the race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age of any contracting party,~~

prospective contracting party, or person reasonably expected to benefit from that contract as an employee or otherwise.

(2) The terms of any contract shall not be modified, and the benefits or coverage of any contract shall not be subject to any limitations, exceptions, exclusions, reductions, copayments, coinsurance, deductibles, reservations, or premium, price, or charge differentials, or other modifications because of the race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age of any contracting party, potential contracting party, or person reasonably expected to benefit from that contract as an employee or otherwise; except that premium, price, or charge differentials because of the sex or age of any individual when based on objective, valid, and up-to-date statistical and actuarial data are not prohibited. Nothing in this section shall be construed to permit an organization to charge different rates to individual employees within the same group solely on the basis of the employee's sex.

(3) It shall be deemed a violation of subdivision (a) for any organization to utilize marital status, living arrangements, occupation, gender, beneficiary designation, ZIP Codes or other territorial classification, or any combination thereof for the purpose of establishing sexual orientation. Nothing in this section shall be construed to alter in any manner the existing law prohibiting organizations from conducting tests for the presence of human immunodeficiency virus or evidence thereof.

(4) This section shall not be construed to limit the authority of the administrative director to adopt or enforce regulations prohibiting discrimination because of sex, marital status, or sexual orientation.

(h) (1) An organization may not use in its name any of the words "insurance," "casualty," "health care service plan," "health plan," "surety," "mutual," or any other words descriptive of the health plan, insurance, casualty, or surety business or use any name similar to the name or description of any health care service plan, insurance, or surety corporation doing business in this state unless that organization controls or is controlled by an entity licensed as a health care service plan or insurer pursuant to the Health and Safety Code or the Insurance Code and the organization employs a name related to that of the controlled or controlling entity.

(2) Section 2415 of the Business and Professions Code, pertaining to fictitious names, does not apply to organizations certified under this section.

(3) An organization or solicitor firm may not adopt a name style that is deceptive, or one that could cause the public to believe the organization is affiliated with or recommended by any governmental or private entity unless this affiliation or endorsement exists.

(i) Each organization shall meet the following requirements:

(1) All facilities located in this state, including, but not limited to, clinics, hospitals, and skilled nursing facilities, to be utilized by the organization shall be licensed by the State Department of Health Services, if that licensure is required by law. Facilities not located in this state shall conform to all licensing and other requirements of the jurisdiction in which they are located.

(2) All personnel employed by or under contract to the organization shall be licensed or certified by their respective board or agency, where that licensure or certification is required by law.

(3) All equipment required to be licensed or registered by law shall be so licensed or registered and the operating personnel for that equipment shall be licensed or certified as required by law.

(4) The organization shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at any time as may be appropriate and consistent with good professional practice.\

(5) All health care shall be readily available at reasonable times to all employees. To the extent feasible, the organization shall make all health care readily accessible to all employees.

(6) The organization shall employ and utilize allied health manpower for the furnishing of health care to the extent permitted by law and consistent with good health care practice.

(7) The organization shall have the organizational and administrative capacity to provide services to employees. The organization shall be able to demonstrate to the department that health care decisions are rendered by qualified providers, unhindered by fiscal and administrative management.

(8) All contracts with employers, insurers of employers, and self-insured employers and all contracts with providers, and other persons furnishing services, equipment, or facilities to or in connection with the workers' compensation health care organization, shall be fair, reasonable, and consistent with the objectives of this part.

(9) Each organization shall provide to employees all workers' compensation health care required by this code. The administrative director shall not determine the scope of workers' compensation health care to be offered by an organization.

(j) (1) Every organization shall establish and maintain a grievance system approved by the administrative director under which employees may submit their grievances to the organization. Each system shall provide reasonable procedures in accordance with regulations adopted by the administrative director that shall ensure adequate consideration of employee grievances and rectification when appropriate.

(2) Every organization shall inform employees upon enrollment and annually thereafter of the procedures for processing and resolving grievances. The information shall include the location and telephone number where grievances may be submitted.

(3) Every organization shall provide forms for complaints to be given to employees who wish to register written complaints. The forms used by organizations shall be approved by the administrative director in advance as to format.

(4) The organization shall keep in its files all copies of complaints, and the responses thereto, for a period of five years.

(k) Every organization shall establish procedures in accordance with regulations of the administrative director for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs. Notwithstanding any other provision of law, there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person who participates in quality of care or utilization reviews by peer review committees that are composed chiefly of physicians, as defined by Section 3209.3, for any act performed during the reviews if the person acts without malice, has made a reasonable

effort to obtain the facts of the matter, and believes that the action taken is warranted by the facts, and neither the proceedings nor the records of the reviews shall be subject to discovery, nor shall any person in attendance at the reviews be required to testify as to what transpired thereat. Disclosure of the proceedings or records to the governing body of an organization or to any person or entity designated by the organization to review activities of the committees shall not alter the status of the records or of the proceedings as privileged communications.

The above prohibition relating to discovery or testimony does not apply to the statements made by any person in attendance at a review who is a party to an action or proceeding the subject matter of which was reviewed, or to any person requesting hospital staff privileges, or in any action against an insurance carrier alleging bad faith by the carrier in refusing to accept a settlement offer within the policy limits, or to the administrative director in conducting surveys pursuant to subdivision (o). This section shall not be construed to confer immunity from liability on any workers' compensation health care organization. In any case in which, but for the enactment of the preceding provisions of this section, a cause of action would arise against an organization, the cause of action shall exist notwithstanding the provisions of this section.

(l) Nothing in this chapter shall be construed to prevent an organization from utilizing subcommittees to participate in peer review activities, nor to prevent an organization from delegating the responsibilities required by subdivision (i) as it determines to be appropriate, to subcommittees including subcommittees composed of a majority of nonphysician health care providers licensed pursuant to the Business and Professions Code, as long as the organization controls the scope of authority delegated and may revoke all or part of this authority at any time. Persons who participate in the subcommittees shall be entitled to the same immunity from monetary liability and actions for civil damages as persons who participate in organization or provider peer review committees pursuant to subdivision (i).

(m) Every organization shall have and shall demonstrate to the administrative director that it has all of the following:

(1) Adequate provision for continuity of care.

(2) A procedure for prompt payment and denial of provider claims.

(n) Every contract between an organization and an employer or insurer of an employer, and every contract between any organization and a provider of health care, shall be in writing.

(o) (1) The administrative director shall conduct periodically an onsite medical survey of the health care delivery system of each organization. The survey shall include a review of the procedures for obtaining health care, the procedures for regulating utilization, peer review mechanisms, internal procedures for assuring quality of care, and the overall performance of the organization in providing health care and meeting the health needs of employees.

(2) The survey shall be conducted by a panel of qualified health professionals experienced in evaluating the delivery of workers' compensation health care. The administrative director shall be authorized to contract with professional organizations or outside personnel to conduct medical surveys. These organizations or personnel shall have demonstrated the ability to objectively evaluate the delivery of this health care.

(3) Surveys performed pursuant to this section shall be conducted as often as deemed necessary by the administrative director to assure the protection of employees, but not less frequently than once every three years. Nothing in this section shall be construed to require the survey team to visit each clinic, hospital, office, or facility of the organization.

(4) Nothing in this section shall be construed to require the medical survey team to review peer review proceedings and records conducted and compiled under this section or in medical records. However, the administrative director shall be authorized to require onsite review of these peer review proceedings and records or medical records where necessary to determine that quality health care is being delivered to employees. Where medical record review is authorized, the survey team shall ensure that the confidentiality of the physician-patient relationship is safeguarded in accordance with existing law and neither the survey team nor the administrative director or the administrative director's staff may be compelled to disclose this information except in accordance with the physician-patient relationship. The administrative director shall ensure that the confidentiality of the peer review proceedings and records is maintained. The disclosure of the peer review proceedings and records to the administrative director or the medical survey team shall not alter the status of the proceedings or records as privileged and confidential communications.

(5) The procedures and standards utilized by the survey team shall be made available to the organizations prior to the conducting of medical surveys.

(6) During the survey, the members of the survey team shall offer such advice and assistance to the organization as deemed appropriate.

(7) The administrative director shall notify the organization of deficiencies found by the survey team. The administrative director shall give the organization a reasonable time to correct the deficiencies, and failure on the part of the organization to comply to the administrative director's satisfaction shall constitute cause for disciplinary action against the organization.

(8) Reports of all surveys, deficiencies, and correction plans shall be open to public inspection, except that no surveys, deficiencies or correction plans shall be made public unless the organization has had an opportunity to review the survey and file a statement of response within 30 days, to be attached to the report.

(p) (1) All records, books, and papers of an organization, management company, solicitor, solicitor firm, and any provider or subcontractor providing medical or other services to an organization, management company, solicitor, or solicitor firm shall be open to inspection during normal business hours by the administrative director.

(2) To the extent feasible, all the records, books, and papers described in paragraph (1) shall be located in this state. In examining those records outside this state, the administrative director shall consider the cost to the organization, consistent with the effectiveness of the administrative director's examination, and may upon reasonable notice require that these records, books, and papers, or a specified portion thereof, be made available for

~~examination in this state, or that a true and accurate copy of these records, books, and papers, or a specified portion thereof, be furnished to the administrative director.~~

~~(q) (1) The administrative director shall conduct an examination of the administrative affairs of any organization, and each person with whom the organization has made arrangements for administrative, or management services, as often as deemed necessary to protect the interest of employees, but not less frequently than once every five years.~~

~~(2) The expense of conducting any additional or nonroutine examinations pursuant to this section, and the expense of conducting any additional or nonroutine medical surveys pursuant to subdivision (o) shall be charged against the organization being examined or surveyed. The amount shall include the actual salaries or compensation paid to the persons making the examination or survey, the expenses incurred in the course thereof, and overhead costs in connection therewith as fixed by the administrative director. In determining the cost of examinations or surveys, the administrative director may use the estimated average hourly cost for all persons performing examinations or surveys of workers' compensation health care organizations for the fiscal year. The amount charged shall be remitted by the organization to the administrative director.~~

~~(3) Reports of all examinations shall be open to public inspection, except that no examination shall be made public, unless the organization has had an opportunity to review the examination report and file a statement or response within 30 days, to be attached to the report.~~

SEC. 28. Section 4601 of the Labor Code is repealed.

~~4601. (a) If the employee so requests, the employer shall tender the employee one change of physician. The employee at any time may request that the employer tender this one-time change of physician. Upon request of the employee for a change of physician, the maximum amount of time permitted by law for the employer or insurance carrier to provide the employee an alternative physician or, if requested by the employee, a chiropractor, or an acupuncturist shall be five working days from the date of the request. Notwithstanding the 30-day time period specified in Section 4600, a request for a change of physician pursuant to this section may be made at any time. The employee is entitled, in any serious case, upon request, to the services of a consulting physician, chiropractor, or acupuncturist of his or her choice at the expense of the employer. The treatment shall be at the expense of the employer.~~

~~(b) If an employee requesting a change of physician pursuant to subdivision (a) has notified his or her employer in writing prior to the date of injury that he or she has a personal chiropractor, the alternative physician tendered by the employer to the employee, if the employee so requests, shall be the employee's personal chiropractor. For the purpose of this article, "personal chiropractor" means the employee's regular chiropractor licensed pursuant to Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code, who has previously directed treatment of the employee, and who retains the employee's chiropractic treatment records, including his or her chiropractic history.~~

~~(c) If an employee requesting a change of physician pursuant to subdivision (a) has notified his or her employer in writing prior to the date of injury that he or she has a personal acupuncturist, the alternative physician tendered by the employer to the employee, if the employee so requests, shall be the employee's personal acupuncturist. For the purpose of this article, "personal acupuncturist" means the employee's regular acupuncturist licensed pursuant to Chapter 12 (commencing with Section 4935) of Division 2 of the Business and Professions Code, who has previously directed treatment of the employee, and who retains the employee's acupuncture treatment records, including his or her acupuncture history.~~

SEC. 29. Section 4602 of the Labor Code is repealed.

~~4602. If the employee so requests, the employer shall procure certification by either the administrative director or the appeals board as the case may be of the competency, for the particular case, of the consulting or additional physicians.~~

SEC. 30. Section 4603 of the Labor Code is repealed.

~~4603. If the employer desires a change of physicians or chiropractor, he may petition the administrative director who, upon a showing of good cause by the employer, may order the employer to provide a panel of five physicians, or if requested by the employee, four physicians and one chiropractor competent to treat the particular case, from which the employee must select one.~~

SEC. 31. Section 4603.2 of the Labor Code is amended to read:

4603.2. (a) Upon selecting a physician pursuant to Section 4600, the employee or physician shall forthwith notify the employer of the name and address of the physician. The physician shall submit a report to the employer within five working days from the date of the initial examination and shall submit periodic reports at intervals that may be prescribed by rules and regulations adopted by the administrative director.

(b) (1) Except as provided in subdivision (d) of Section 4603.4, payment for medical treatment provided or authorized by the treating physician selected by the employee or designated by the employer shall be made by the employer within 45 working days after receipt of each separate, itemized billing, together with any required report and any written authorization for services that may have been received by the physician. If the billing or a portion thereof is contested, denied, or considered incomplete, the physician shall be notified, in writing, that the billing is contested, denied, or considered incomplete, within 30 working days after receipt of the billing by the employer. A notice that a billing is incomplete shall state all additional information required to make a decision. Any properly documented amount not paid within the 45-working-day period shall be increased by 15 percent, together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill, unless the employer does both of the following:

(A) Pays the uncontested amount within the 45-working-day period.

(B) Advises, in the manner prescribed by the administrative director, the physician, or another provider of the items being contested, the reasons for contesting these items, and the remedies available to the physician or the other provider if he or she disagrees. In the case of a bill which includes charges from a hospital, outpatient surgery center, or independent diagnostic facility, advice that a request has been

made for an audit of the bill shall satisfy the requirements of this paragraph.

If an employer contests all or part of a billing, ~~any~~ *the* amount determined payable by the appeals board shall carry interest from the date the amount was due until it is paid. If ~~any~~ *the* contested amount is determined payable by the appeals board, the defendant shall be ordered to reimburse the ~~provider~~ *lien holder* for any filing fees paid pursuant to Section 4903.05.

An employer's liability to a physician or another provider under this section for delayed payments shall not affect its liability to an employee under Section 5814 or any other provision of this division.

(2) Notwithstanding paragraph (1), if the employer is a governmental entity, payment for medical treatment provided or authorized by the treating physician selected by the employee or designated by the employer shall be made within 60 working days after receipt of each separate, itemized billing, together with any required reports and any written authorization for services that may have been received by the physician.

(c) Any interest or increase in compensation paid by an insurer pursuant to this section shall be treated in the same manner as an increase in compensation under subdivision (d) of Section 4650 for the purposes of any classification of risks and premium rates, and any system of merit rating approved or issued pursuant to Article 2 (commencing with Section 11730) of Chapter 3 of Part 3 of Division 2 of the Insurance Code.

(d) (1) Whenever an employer or insurer employs an individual or contracts with an entity to conduct a review of a billing submitted by a physician or medical provider, the employer or insurer shall make available to that individual or entity all documentation submitted together with that billing by the physician or medical provider. When an individual or entity conducting a bill review determines that additional information or documentation is necessary to review the billing, the individual or entity shall contact the claims administrator or insurer to obtain the necessary information or documentation that was submitted by the physician or medical provider pursuant to subdivision (b).

(2) An individual or entity reviewing a bill submitted by a physician or medical provider shall not alter the procedure codes billed or recommend reduction of the amount of the bill unless the documentation submitted by the physician or medical provider with the bill has been reviewed by that individual or entity. If the reviewer does not recommend payment as billed by the physician or medical provider, the explanation of review shall provide the physician or medical provider with a specific explanation as to why the reviewer altered the procedure code or amount billed and the specific deficiency in the billing or documentation that caused the reviewer to conclude that the altered procedure code or amount recommended for payment more accurately represents the service performed.

(3) The appeals board shall have jurisdiction over disputes arising out of this subdivision pursuant to Section 5304.

(e) This section shall not apply to employees and employers to whom Section 4600.3 and 4600.31 applies.

SEC. 32. Section 4604 of the Labor Code is amended to read:

4604. Controversies between *an* employer and employee arising under this chapter shall be determined by the appeals board, upon the request of either party~~.~~ *, unless the controversy is subject to independent medical review as set forth in Section 4611 or, for those employees and employers to whom Section 4600.3 or 4600.31 applies, where controversies are determined pursuant to the contract.*

SEC. 33. Section 4604.5 of the Labor Code is amended to read:

4604.5. (a) Upon adoption by the administrative director of a medical treatment utilization schedule pursuant to Section 5307.27, the recommended guidelines set forth in the schedule shall be presumptively correct on the issue of extent and scope of medical treatment. ~~The presumption is rebuttable and may be controverted by a preponderance of the evidence establishing that a variance from the guidelines is reasonably required to cure and relieve the employee from the effects of his or her injury.~~ *The presumption created is one affecting the burden of proof.*

~~(b) The recommended guidelines set forth in the schedule adopted pursuant to subdivision (a) shall reflect practices as generally accepted by the health care community, and shall apply the current standards of care, including, but not limited to, appropriate and inappropriate diagnostic techniques, treatment modalities, adjustive modalities, length of treatment, and appropriate specialty referrals. These guidelines shall be educational and designed to assist providers by offering an analytical framework for the evaluation and treatment of the more common problems of injured workers, and shall assure appropriate and necessary care for all injured workers diagnosed with industrial conditions.~~

(b) ~~(c)~~ Three months after the publication date of the updated American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines, and continuing until the effective date of a medical treatment utilization schedule, pursuant to Section 5307.27, the recommended guidelines set forth in the American College of Occupational and Environmental Medical Practice Guidelines shall be presumptively correct on the issue of extent and scope of medical treatment. ~~The presumption is rebuttable and may be controverted by a preponderance of the evidence establishing that a variance from the guidelines is reasonably required to cure and relieve the employee from the effects of his or her injury.~~ *The presumption created is one affecting the burden of proof.*

(c) ~~(d)~~ Notwithstanding the medical treatment utilization schedule or the guidelines set forth in the American College of Occupational and Environmental Medical Practice Guidelines, for injuries occurring on and after January 1, 2004, an employee shall be entitled to no more than 24 chiropractic and 24 physical therapy visits per industrial injury *unless the employer authorizes, in writing, additional visits to a health care practitioner for physical medicine services.*

~~(e) The presumption afforded to the treating physician in Section 4062.9 shall not be applicable to cases arising under this section.~~

~~(f) This section shall not apply when an insurance carrier authorizes, in writing, additional visits to a health care practitioner for physical medicine services.~~

(d) ~~(g)~~ For all injuries not covered by the American College of Occupational and Environmental Medicine Occupational Medicine Practice Guidelines or official utilization schedule after adoption pursuant to Section 5307.27, authorized treatment shall be in accordance with other evidence based medical treatment guidelines

~~generally recognized by the medical community~~ *recognized by the national medical community and that are scientifically based.*

(e) ~~*(h)*~~ *This section shall not apply to employees and employers to whom Section 4600.3 or 4600.31 applies.*

SEC. 34. Section 4609 of the Labor Code is repealed.

~~4609. (a) In order to prevent the improper selling, leasing, or transferring of a health care provider's contract, it is the intent of the Legislature that every arrangement that results in any payor paying a health care provider a reduced rate for health care services based on the health care provider's participation in a network or panel shall be disclosed by the contracting agent to the provider in advance and shall actively encourage employees to use the network, unless the health care provider agrees to provide discounts without that active encouragement.~~

~~(b) Beginning July 1, 2000, every contracting agent that sells, leases, assigns, transfers, or conveys its list of contracted health care providers and their contracted reimbursement rates to a payor, as defined in subparagraph (A) of paragraph (3) of subdivision (d), or another contracting agent shall, upon entering or renewing a provider contract, do all of the following:~~

~~(1) Disclose whether the list of contracted providers may be sold, leased, transferred, or conveyed to other payors or other contracting agents, and specify whether those payors or contracting agents include workers' compensation insurers or automobile insurers.~~

~~(2) Disclose what specific practices, if any, payors utilize to actively encourage employees to use the list of contracted providers when obtaining medical care that entitles a payor to claim a contracted rate. For purposes of this paragraph, a payor is deemed to have actively encouraged employees to use the list of contracted providers if the employer provides information directly to employees during the period the employer has medical control advising them of the existence of the list of contracted providers through the use of a variety of advertising or marketing approaches that supply the names, addresses, and telephone numbers of contracted providers to employees; or in advance of a workplace injury, or upon notice of an injury or claim by an employee, the approaches may include, but are not limited to, the use of provider directories, the use of a list of all contracted providers in an area geographically accessible to the posting site, the use of wall cards that direct employees to a readily accessible listing of those providers at the same location as the wall cards, the use of wall cards that direct employees to a toll-free telephone number or Internet Web site address, or the use of toll-free telephone numbers or Internet Web site addresses supplied directly during the period the employer has medical control. However, Internet Web site addresses alone shall not be deemed to satisfy the requirements of this paragraph. Nothing in this paragraph shall prevent contracting agents or payors from providing only listings of providers located within a reasonable geographic range of an employee. A payor who otherwise meets the requirements of this paragraph is deemed to have met the requirements of this paragraph regardless of the employer's ability to control medical treatment pursuant to Sections 4600 and 4600.3.~~

~~(3) Disclose whether payors to which the list of contracted providers may be sold, leased, transferred, or conveyed may be permitted to pay a provider's contracted rate without actively encouraging the employees to use the list of contracted providers when obtaining medical care. Nothing in this subdivision shall be construed to require a payor to actively encourage the employees to use the list of contracted providers when obtaining medical care in the case of an emergency.~~

~~(4) Disclose, upon the initial signing of a contract, and within 15 business days of receipt of a written request from a provider or provider panel, a payor summary of all payors currently eligible to claim a provider's contracted rate due to the provider's and payor's respective written agreements with any contracting agent.~~

~~(5) Allow providers, upon the initial signing, renewal, or amendment of a provider contract, to decline to be included in any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the employees to use the list of contracted providers when obtaining medical care as described in paragraph (2). Each provider's election under this paragraph shall be binding on the contracting agent with which the provider has the contract and any other contracting agent that buys, leases, or otherwise obtains the list of contracted providers. A provider shall not be excluded from any list of contracted providers that is sold, leased, transferred, or conveyed to payors that actively encourage the employees to use the list of contracted providers when obtaining medical care, based upon the provider's refusal to be included on any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the employees to use the list of contracted providers when obtaining medical care.~~

~~(6) If the payor's explanation of benefits or explanation of review does not identify the name of the network that has a written agreement signed by the provider whereby the payor is entitled, directly or indirectly, to pay a preferred rate for the services rendered, the contracting agent shall do the following:~~

~~(A) Maintain a Web site that is accessible to all contracted providers and updated at least quarterly and maintain a toll-free telephone number accessible to all contracted providers whereby providers may access payor summary information.~~

~~(B) Disclose through the use of an Internet Web site, a toll-free telephone number, or through a delivery or mail service to its contracted providers, within 30 days, any sale, lease assignment, transfer or conveyance of the contracted reimbursement rates to another contracting agent or payor.~~

~~(7) Nothing in this subdivision shall be construed to impose requirements or regulations upon payors, as defined in subparagraph (A) of paragraph (3) of subdivision (d).~~

~~(c) Beginning July 1, 2000, a payor, as defined in subparagraph (B) of paragraph (3) of subdivision (d), shall do all of the following:~~

~~(1) Provide an explanation of benefits or explanation of review that identifies the name of the network with which the payor has an agreement that entitles them to pay a preferred rate for the services rendered.~~

~~(2) Demonstrate that it is entitled to pay a contracted rate within 30 business days of receipt of a written request from a provider who has received a claim payment from the payor. The provider shall include in the request a statement explaining why the payment is not at the correct contracted rate for the services provided. The~~

~~failure of the provider to include a statement shall relieve the payor from the responsibility of demonstrating that it is entitled to pay the disputed contracted rate. The failure of a payor to make the demonstration to a properly documented request of the provider within 30 business days shall render the payor responsible for the lesser of the provider's actual fee or, as applicable, any fee schedule pursuant to this division, which amount shall be due and payable within 10 days of receipt of written notice from the provider, and shall bar the payor from taking any future discounts from that provider without the provider's express written consent until the payor can demonstrate to the provider that it is entitled to pay a contracted rate as provided in this subdivision. A payor shall be deemed to have demonstrated that it is entitled to pay a contracted rate if it complies with either of the following:~~

~~(A) Describes the specific practices the payor utilizes to comply with paragraph (2) of subdivision (b), and demonstrates compliance with paragraph (1).~~

~~(B) Identifies the contracting agent with whom the payor has a written agreement whereby the payor is not required to actively encourage employees to use the list of contracted providers pursuant to paragraph (5) of subdivision (b).~~

~~(d) For the purposes of this section, the following terms have the following meanings:~~

~~(1) "Contracting agent" means an insurer licensed under the Insurance Code to provide workers' compensation insurance, a health care service plan, including a specialized health care service plan, a preferred provider organization, or a self-insured employer, while engaged, for monetary or other consideration, in the act of selling, leasing, transferring, assigning, or conveying a provider or provider panel to provide health care services to employees for work-related injuries.~~

~~(2) "Employee" means a person entitled to seek health care services for a work-related injury.~~

~~(3) (A) For the purposes of subdivision (b), "payor" means a health care service plan, including a specialized health care service plan, an insurer licensed under the Insurance Code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, or workers' compensation insurance, or a self-insured employer that is responsible to pay for health care services provided to beneficiaries.~~

~~(B) For the purposes of subdivision (e), "payor" means an insurer licensed under the Insurance Code to provide workers' compensation insurance, a self-insured employer, a third-party administrator or trust, or any other third party that is responsible to pay health care services provided to employees for work-related injuries, or an agent of an entity included in this definition.~~

~~(4) "Payor summary" means a written summary that includes the payor's name and the type of plan, including, but not limited to, a group health plan, an automobile insurance plan, and a workers' compensation insurance plan.~~

~~(5) "Provider" means any of the following:~~

~~(A) Any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code.~~

~~(B) Any person licensed pursuant to the Chiropractic Initiative Act or the Osteopathic Initiative Act.~~

~~(C) Any person licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.~~

~~(D) A clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.~~

~~(E) Any entity exempt from licensure pursuant to Section 1206 of the Health and Safety Code.~~

~~(e) This section shall become operative on July 1, 2000.~~

SEC. 35. *Section 4611 is added to the Labor Code, to read:*

4611. (a) Commencing July 1, 2004, there is hereby established the Independent Medical Review System that shall resolve disputes involving any disputed health care service.

(b) "Health care service" means any medical treatment, as defined in Section 4600, recommended by a physician, as defined in Section 3209.3, or any disputed diagnostic service recommended by a physician, as defined in Section 3209.3.

(c) A dispute over health care service may be submitted by an employee or employer with respect to the denial, modification, delay, or approval of any health care service.

(d) In order to request independent medical review under this article, the employee or employer requesting review shall submit to the administrative director a one-page application. All applications for dispute that meet the requirements of this section shall be reviewed. Except as to issues regarding the permanent and stationary status of the applicant, an applicant is required to have first participated in the process pursuant to Section 4610 in order to be eligible for independent medical review.

(e) The administrative director shall notify the court administrator of all requests for independent medical review within five days of receipt of the request. The court administrator shall determine whether the claim of the injured worker seeking independent medical review is subject to any additional disputed issue over which the appeals board has jurisdiction. If such a dispute exists, the court administrator shall promptly notify the board that there is an independent medical review of medical issues in the claim.

(f) As used in this division, "permanent and stationary" means that, based on objective findings of medical evidence, no further material improvement would reasonably be expected from additional medical treatment or the passage of time. Notwithstanding any other provision of law, disputes regarding whether an employee is permanent and stationary shall be resolved by the independent medical review system created by this section.

SEC. 36. *Section 4611.1 is added to the Labor Code, to read:*

4611.1. (a) The administrative director may contract with one or more independent medical review organizations in the state to conduct reviews for purposes of Section 4611. The administrative director may establish additional requirements, including conflict-of-interest standards, consistent with the purposes of this article, that an organization shall be required to meet in order to qualify for participation in the Independent Medical Review System and to assist the department in carrying out its responsibilities.

(b) The independent medical review organizations and the medical professionals selected by these organizations to conduct

reviews shall be deemed to be medical consultants for purposes of Section 43.98 of the Civil Code.

(c) An independent medical review organization shall conduct the review in accordance with any regulations or orders of the administrative director. The organization's review shall be limited to an examination of the medical necessity of the disputed medical treatment services and shall not include any consideration of compensability or other legal issues.

(d) Neither the independent medical review organization, nor any experts it designates to conduct a review, shall have any material professional, familial, or financial affiliation, as determined by the administrative director, with any of the following:

(1) The employer, the employer's workers' compensation insurer or third-party claims administrator, or any other entity contracting with the employer to provide utilization review services pursuant to Section 4610.

(2) Any officer, director, or employee of the employer's health care provider, workers' compensation insurer, or third-party claims administrator.

(3) A physician, the physician's medical group, or the independent practice association involved in the health care service in dispute.

(4) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the employer's health care provider, workers' compensation insurer, or third-party claims administrator, would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the employee or his or her treating physician whose treatment is under review, or the alternative therapy, if any, recommended by the employer or other entity.

(6) The employee or the employee's immediate family.

(7) The employee's or employer's legal representative or the legal representative's immediate family.

(e) In order to contract with the division for purposes of this section, an independent medical review organization shall meet all of the requirements of the administrative director and shall not be an affiliate, parent organization, or subsidiary of, nor in any way be owned or controlled by, a workers' compensation insurer or third-party claims administrator.

(f) Upon receipt of information and documents related to a case, the medical professional reviewer or reviewers selected to conduct the review by the independent medical review organization shall promptly review all pertinent medical records of the employee, medical provider reports, as well as any other information submitted to the organization as authorized by the division or requested by the reviewers from any of the parties to the dispute. If reviewers request information from any of the parties, a copy of the request and the response shall be provided to all of the parties. The reviewer or reviewers shall also review relevant information related to the criteria set forth in subdivision (g).

(g) Following its review, the reviewer or reviewers shall determine whether the disputed health care service was medically necessary based on peer-reviewed scientific and objective findings based on medical evidence regarding the effectiveness of the disputed service.

(h) The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, within 30 days of the receipt of the application for review and supporting documentation, or within less time as prescribed by the administrative director. If the disputed medical treatment service has not been provided and the employee's provider or the division certifies in writing that an imminent and serious threat to the health of the employee may exist, the analyses and determinations of the reviewers shall be expedited and rendered within three days of the receipt of the information. Subject to the approval of the administrative director, reviews may be extended for up to three days in extraordinary circumstances or for good cause. The administrative director shall adopt regulations specifying a standardized format for, and minimum required elements of, determinations made pursuant to this section.

(i) The medical professionals' analyses and determinations shall state whether the disputed health care service is medically necessary. Each analysis shall cite the employee's medical condition, the relevant documents in the record, and any relevant findings associated to support the determination.

(j) The independent medical review organization shall promptly serve the administrative director, the employer, the employee, and the employee's treating physician with the analyses and determinations of the medical professionals reviewing the case, and a description of the qualifications of the medical professionals. The determination shall be accompanied by a notice, in a form determined by the administrative director, informing the parties of their appeal rights. The independent medical review organization shall keep the names of the reviewers confidential in all communications with entities or individuals outside the independent medical review organization, except in response to orders of the appeals board or a court. If more than one medical professional reviewed the case and the result was differing determinations, the independent medical review organization shall provide each of the separate reviewer's analyses and determinations.

(k) The determination of the independent medical review shall be final and binding upon the parties to the dispute. The determination may not be appealed to the division, a workers' compensation administrative law judge, or the board. Upon a determination by the independent medical treatment review organization that the disputed medical treatment is medically necessary, the employer or other entity shall authorize the disputed medical treatment.

(l) The independent medical review record shall be admissible before the appeals board.

(m) The independent medical review record shall be made available to a qualified medical examiner or an agreed medical examiner if disputes arise over the compensability of the same injury or need for continuing medical treatment as was the subject of the independent medical review. Either party to the dispute over compensability may make the independent medical review available to the QME/AME.

SEC. 37. Section 4614 of the Labor Code is repealed.

~~4614. (a) (1) Notwithstanding Section 5307.1, where the employee's individual or organizational provider of health care services rendered under this division and paid on a fee-for-service basis is also the provider of health care services under contract with~~

~~the employee's health benefit program, and the service or treatment provided is included within the range of benefits of the employee's health benefit program, and paid on a fee-for-service basis, the amount of payment for services provided under this division, for a work-related occurrence or illness, shall be no more than the amount that would have been paid for the same services under the health benefit plan, for a non-work-related occurrence or illness.~~

~~(2) A health care service plan that arranges for health care services to be rendered to an employee under this division under a contract, and which is also the employee's organizational provider for nonoccupational injuries and illnesses, with the exception of a nonprofit health care service plan that exclusively contracts with a medical group to provide or arrange for medical services to its enrollees in a designated geographic area, shall be paid by the employer for services rendered under this division only on a capitated basis.~~

~~(b) (1) Where the employee's individual or organizational provider of health care services rendered under this division who is not providing services under a contract is not the provider of health care services under contract with the employee's health benefit program or where the services rendered under this division are not within the benefits provided under the employer-sponsored health benefit program, the provider shall receive payment that is no more than the average of the payment that would have been paid by five of the largest preferred provider organizations by geographic region. Physicians, as defined in Section 3209.3, shall be reimbursed at the same averaged rates, regardless of licensure, for the delivery of services under the same procedure code. This subdivision shall not apply to a health care service plan that provides its services on a capitated basis.~~

~~(2) The administrative director shall identify the regions and the five largest carriers in each region. The carriers shall provide the necessary information to the administrative director in the form and manner requested by the administrative director. The administrative director shall make this information available to the affected providers on an annual basis.~~

~~(c) Nothing in this section shall prohibit an individual or organizational health care provider from being paid fees different from those set forth in the official medical fee schedule by an employer, insurance carrier, third-party administrator on behalf of employers, or preferred provider organization representing an employer or insurance carrier provided that the administrative director has determined that the alternative negotiated rates between the organizational or individual provider and a payer, a third-party administrator on behalf of employers, or a preferred provider organization will produce greater savings in the aggregate than if each item on billings were to be charged at the scheduled rate.~~

~~(d) For the purposes of this section, "organizational provider" means an entity that arranges for health care services to be rendered directly by individual caregivers. An organizational provider may be a health care service plan, disability insurer, health care organization, preferred provider organization, or workers' compensation insurer arranging for care through a managed care network or on a fee-for-service basis. An individual provider is either an individual or institution that provides care directly to the injured worker.~~

SEC. 38. Section 4614.1 of the Labor Code is repealed.

~~4614.1. Notwithstanding subdivision (f) of Section 1345 of the Health and Safety Code, a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act and certified by the administrative director pursuant to Section 4600.5 to provide health care pursuant to Section 4600.3 shall be permitted to accept payment from a self-insured employer, a group of self-insured employers, or the insurer of an employer on a fee-for-service basis for the provision of such health care as long as the health care service plan is not both the health care organization in which the employee is enrolled and the plan through which the employee receives regular health benefits.~~

SEC. 39. Section 4658 of the Labor Code is amended to read:

4658. (a) For injuries occurring prior to January 1, 1992, if the injury causes permanent disability, the percentage of disability to total disability shall be determined, and the disability payment computed and allowed, according to paragraph (1). However, in no event shall the disability payment allowed be less than the disability payment computed according to paragraph (2).

(1)

Column 1--Range of percentage of permanent disability incurred:	Column 2--Number of weeks for which two-thirds of average weekly earnings allowed for each 1 percent of permanent disability within percentage range:
Under 10	3
10-19.75	4
20-29.75	5
30-49.75	6
50-69.75	7
70-99.75	8

The number of weeks for which payments shall be allowed set forth in column 2 above based upon the percentage of permanent disability set forth in column 1 above shall be cumulative, and the number of benefit weeks shall increase with the severity of the disability. The following schedule is illustrative of the computation of the number of benefit weeks:

Column 1--Percentage of permanent disability incurred:	Column 2--Cumulative number of benefit weeks:
5	15.00
10	30.25
15	50.25
20	70.50
25	95.50
30	120.75
35	150.75
40	180.75
45	210.75
50	241.00
55	276.00
60	311.00
65	346.00

70	381.25
75	421.25
80	461.25
85	501.25
90	541.25
95	581.25
100	for life

(2) Two-thirds of the average weekly earnings for four weeks for each 1 percent of disability, where, for the purposes of this subdivision, the average weekly earnings shall be taken at not more than seventy-eight dollars and seventy-five cents ($78.75).

(b) This subdivision shall apply to injuries occurring on or after January 1, 1992. If the injury causes permanent disability, the percentage of disability to total disability shall be determined, and the disability payment computed and allowed, according to paragraph (1). However, in no event shall the disability payment allowed be less than the disability payment computed according to paragraph (2).

(1)

Column 1--Range of percentage of permanent disability incurred:	Column 2--Number of weeks for which two-thirds of average weekly earnings allowed for each 1 percent of permanent disability within percentage range:
Under 10	3
10-19.75	4
20-24.75	5
25-29.75	6
30-49.75	7
50-69.75	8
70-99.75	9

The numbers set forth in column 2 above are based upon the percentage of permanent disability set forth in column 1 above and shall be cumulative, and shall increase with the severity of the disability in the manner illustrated in subdivision (a).

(2) Two-thirds of the average weekly earnings for four weeks for each 1 percent of disability, where, for the purposes of this subdivision, the average weekly earnings shall be taken at not more than seventy-eight dollars and seventy-five cents ($78.75).

(c) This subdivision shall apply to injuries occurring on or after January 1, 2004. If the injury causes permanent disability, the percentage of disability to total disability shall be determined, and the disability payment computed and allowed as follows:

Column 1--Range of percentage of permanent disability incurred:	Column 2--Number of weeks for which two-thirds of average weekly earnings allowed for each 1 percent of permanent disability within percentage range:
Under 10	4
10-19.75	5
20-24.75	5
25-29.75	6
30-49.75	7
50-69.75	8
70-99.75	9

The numbers set forth in column 2 above are based upon the percentage of permanent disability set forth in column 1 above and shall be cumulative, and shall increase with the severity of the disability in the manner illustrated in subdivision (a).

(d) This subdivision shall apply to injuries occurring on or after January 1, 2005. If the injury causes permanent disability, the percentage of disability to total disability shall be determined, and the disability payment computed and allowed as follows:

Column 1--Range of percentage of permanent disability incurred:	*Column 2--Number of weeks for which two-thirds of average weekly earnings allowed for each 1 percent of permanent disability within percentage range:*
Under 10	*4*
10-19.75	*5*
20-24.75	*5*
25-29.75	*6*
30-49.75	*7*
50-69.75	*8*
70-99.75	*14*

The numbers set forth in column 2 above are based upon the percentage of permanent disability set forth in column 1 above and shall be cumulative, and shall increase with the severity of the disability in the manner illustrated in subdivision (a).

SEC. 40. Section 4658.6 of the Labor Code is amended to read:

4658.6. The employer shall not be liable for the supplemental job displacement benefit if the employer meets either of the following conditions:

(a) Within 30 days of the termination of temporary disability indemnity payments, the employer offers, and the employee, *within 30 days from the date of the offer*, rejects, or fails to accept in the form and manner prescribed by the administrative director, modified work, accommodating the employee's work restrictions, lasting at least 12 months.

(b) Within 30 days of the termination of temporary disability indemnity payments, the employer offers, and the employee, *within 30 days from the date of the offer*, rejects, or fails to accept in the form and manner prescribed by the administrative director, alternative work meeting all of the following conditions:

(1) The employee has the ability to perform the essential functions of the job provided.

(2) The job provided is in a regular position lasting at least 12 months.

(3) The job provided offers wages and compensation that are within 15 percent of those paid to the employee at the time of injury.

(4) The job is located within reasonable commuting distance of the employee's residence at the time of injury.

SEC. 41. Section 4660 of the Labor Code is amended to read:

4660. (a) In determining the percentages of permanent disability, account shall be taken of the nature of the physical injury or

disfigurement, *established by a preponderance of medical evidence based upon objective findings, as defined in paragraph (2) of subdivision (j) of Section 139.2,* the occupation of the injured employee, and his *or her* age at the time of ~~such~~ *the* injury, consideration being given to the ~~diminished ability of such~~ injured ~~employee to compete in an open labor market~~ *employee's adaptability to perform a given job, provided however:*

(1) The nature of the physical injury or disfigurement shall be the sole factor to be considered in determining percentages of permanent disability if any of the following circumstances exist:

(A) The employee returns to regular work at the job held at the time of injury.

(B) The treating physician releases the injured employee to regular work at the job held at the time of injury and the job is available but the worker refuses to return to that job.

(C) The treating physician releases the injured employee to regular work at the job held at the time of injury but the worker's employment is terminated for cause unrelated to the injury.

(2) The nature of the physical injury or disfigurement, the occupation of the injured employee, and his or her age at the time of the injury shall be the sole factors to be considered in determining percentages of permanent disability if any of the following circumstances exist:

(A) The employee returns to modified or alternative work with the same employer that provides wages and compensation that are not less than 85 percent of those paid to the employee at the time of injury and, if the job is not at the same physical location as the job held at the time of injury, the job is located within reasonable commuting distance of the employee's residence at the time of injury.

(B) The treating physician releases the injured employee to regular work at the job offered pursuant to this subdivision and the job is available but the worker refuses to return to that job.

(C) The treating physician releases the injured employee to regular work at the job offered pursuant to this subdivision but the worker's employment is terminated for cause unrelated to the injury.

(b) (1) The administrative director ~~may~~ *shall* prepare, adopt, and from time to time amend, a schedule for the determination of the percentage of permanent disabilities in accordance with this section. ~~Such~~ *The* schedule shall be available for public inspection,- and , without formal introduction in evidence shall be prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule.

~~(c) Any such schedule and any amendment thereto or revision thereof shall apply prospectively and shall apply to and govern only those permanent disabilities which result from compensable injuries received or occurring on and after the effective date of the adoption of such schedule, amendment or revision, as the fact may be.~~

~~(d) On or before January 1, 1995, the administrative director shall review and revise the schedule for the determination of the percentage of permanent disabilities. The revision shall include, but not be limited to, an updating of the standard disability ratings and occupations to reflect the current labor market. However, no change in standard disability ratings shall be adopted without the approval of the Commission of Health and Safety and Workers' Compensation. A proposed revision shall be submitted to the commission on or before July 1, 1994.~~ *The schedule shall promote uniformity of ratings for substantially similar disabilities throughout the state, and for injuries not subject to subsection (1) and subsection (2) of subdivision (a) shall set forth a methodology for determining the percentage of permanent disability that gives appropriate weight to each of the factors of disability set forth in subdivision (a). The schedule shall be promulgated and administered to reflect the effects of physical injury or disfigurement on the individual worker in combination with the injured worker's adaptability to perform a given job. The schedule shall not allow for the determination of the percentage of permanent disability to be determined solely upon the assessment of the adaptability of the worker to perform a given job. The administrative director shall adopt, as an emergency regulation, changes to the schedule to reflect medical conditions or occupational classifications that were not in effect at the time of the promulgation of the schedule within 30 days after actual notice that a compensable injury or an occupation at the time of injury was not set forth in the schedule at the time the injury took place. In developing the schedule, the administrative director may utilize for reference nationally recognized guidelines for impairment.*

(2) The adoption, amendment, repeal, or readoption of the regulations that the administrative director is authorized pursuant to paragraph (1) to adopt as emergency regulations are deemed to be necessary for the immediate preservation of the public peace, health and safety, or general welfare, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the administrative director is hereby exempted from the requirement that it describe specific facts showing the need for immediate action. For purposes of subdivision (e) of Section 11346.1 of the Government Code, the 120-day period, as applicable to the effective period of an emergency regulatory action and submission of specified materials to the Office of Administrative Law, is hereby extended to 180 days.

(c) For compensable claims arising before the effective date of the schedule and any amendment thereto or revision thereof, the revised schedule shall apply to the determination of permanent disabilities where there has either been no comprehensive medical-legal report, or report by a treating physician, indicating the existence of permanent disability, or where the employer is not required to provide the notice required by Section 4061 to the injured worker.

SEC. 42. Section 5304 of the Labor Code is amended to read:

5304. The appeals board has jurisdiction over any controversy relating to or arising out of Sections 4600 to 4605 inclusive, unless an express agreement fixing the amounts to be paid for medical, surgical or hospital treatment as such treatment is described in those sections has been made between the persons or institutions rendering such treatment and the employer or insurer- , *or unless the controversy is either subject to independent medical review as set forth in Section 4611 or, for those employees and employers to whom Section 4600 or 4600.31 applies, controversies are determined pursuant to the contract.*

SEC. 43. Section 5307.1 of the Labor Code is amended to read:

5307.1. (a) The administrative director, after public hearings, shall adopt and revise periodically an official medical fee schedule that shall establish reasonable maximum fees paid for medical services ~~other than physician services~~, drugs and pharmacy services, health care facility fees, home health care, and all other treatment, care, services, and goods described in Section 4600 and provided pursuant to this section. Except for physician services, all fees shall be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems, provided that employer liability for medical treatment, including issues of reasonableness, necessity, frequency, and duration, shall be determined in accordance with Section 4600. Commencing January 1, 2004, and continuing until the time the administrative director has adopted an official medical fee schedule in accordance with the fee-related structure and rules of the relevant Medicare payment systems, except for the components listed in subdivisions (k) and (l), maximum reasonable fees shall be 120 percent of the estimated aggregate fees prescribed in the relevant Medicare payment system for the same class of services before application of the inflation factors provided in subdivision ~~(e)~~ (g), except that for pharmacy services and drugs that are not otherwise covered by a Medicare fee schedule payment for facility services, the maximum reasonable fees shall be ~~100~~ *110%* percent of fees prescribed in the relevant Medi-Cal payment system. Upon adoption by the administrative director of an official medical fee schedule pursuant to this section, the maximum reasonable fees paid shall not exceed 120 percent of estimated aggregate fees prescribed in the Medicare payment system for the same class of services before application of the inflation factors provided in subdivision ~~(e)~~ (g). Pharmacy services and drugs shall be subject to the requirements of this section, whether furnished through a pharmacy or dispensed directly by the practitioner pursuant to subdivision (b) of Section 4024 of the Business and Professions Code.

(b) In order to comply with the standards specified in subdivision (f), the administrative director may adopt different conversion factors, diagnostic related group weights, and other factors affecting payment amounts from those used in the Medicare payment system, provided estimated aggregate fees do not exceed 120 percent of the estimated aggregate fees paid for the same class of services in the relevant Medicare payment system.

(c) Notwithstanding subdivisions (a) and (d), the maximum facility fee for services performed in an ambulatory surgical center, or in a hospital outpatient department, may not exceed 120 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department.

(d) If the administrative director determines that a medical treatment, facility use, product, or service is not covered by a Medicare payment system, the administrative director shall establish maximum fees for that item, provided that the maximum fee paid shall not exceed 120 percent of the fees paid by Medicare for services that require comparable resources. If the administrative director determines that a pharmacy service or drug is not covered by a Medi-Cal payment system, the administrative director shall establish maximum fees for that item, provided, however, that the maximum fee paid shall not exceed ~~100~~ *110* percent of the fees paid by Medi-Cal for pharmacy services or drugs that require comparable resources.

(e) Prior to the adoption by the administrative director of a medical fee schedule pursuant to this section, for any treatment, facility use, product, or service not covered by a Medicare payment system, including acupuncture services, or, with regard to pharmacy services and drugs, for a pharmacy service or drug that is not covered by a Medi-Cal payment system, the maximum reasonable fee paid shall not exceed the fee specified in the official medical fee schedule in effect on December 31, 2003.

(f) Within the limits provided by this section, the rates or fees established shall be adequate to ensure a reasonable standard of services and care for injured employees.

(g) (1) (A) Notwithstanding any other provision of law, the official medical fee schedule shall be adjusted to conform to any relevant changes in the Medicare and Medi-Cal payment systems no later than 60 days after the effective date of those changes, provided that both of the following conditions are met:

(i) The annual inflation adjustment for facility fees for inpatient hospital services provided by acute care hospitals and for hospital outpatient services shall be determined solely by the estimated increase in the hospital market basket for the 12 months beginning October 1 of the preceding calendar year.

(ii) The annual update in the operating standardized amount and capital standard rate for inpatient hospital services provided by hospitals excluded from the Medicare prospective payment system for acute care hospitals and the conversion factor for hospital outpatient services shall be determined solely by the estimated increase in the hospital market basket for excluded hospitals for the 12 months beginning October 1 of the preceding calendar year. (B) The update factors contained in clauses (i) and (ii) of subparagraph (A) shall be applied beginning with the first update in the Medicare fee schedule payment amounts after December 31, 2003.

(2) The administrative director shall determine the effective date of the changes, and shall issue an order, exempt from Sections 5307.3 and 5307.4 and the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11370) of Part 1 of Division 3 of Title 2 of the Government Code), informing the public of the changes and their effective date. All orders issued pursuant to this paragraph shall be published on the Internet Web site of the Division of Workers' Compensation.

(3) For the purposes of this subdivision, the following definitions apply:

(A) "Medicare Economic Index" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of a providing physician and other services paid under the resource-based relative value scale.

(B) "Hospital market basket" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of providing inpatient hospital services provided by acute care hospitals that are included in the Medicare prospective payment system.

(C) "Hospital market basket for excluded hospitals" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of providing inpatient services by hospitals that are excluded from the Medicare prospective payment system.

(h) Nothing in this section shall prohibit an employer or insurer from contracting with a medical provider for reimbursement rates different from those prescribed in the official medical fee schedule.
(i) Except as provided in Section 4626, the official medical fee schedule shall not apply to medical-legal expenses, as that term is defined by Section 4620.
(j) The following Medicare payment system components may not become part of the official medical fee schedule until January 1, 2005:
(1) Inpatient skilled nursing facility care.
(2) Home health agency services.
(3) Inpatient services furnished by hospitals that are exempt from the prospective payment system for general acute care hospitals. (4) Outpatient renal dialysis services.
(k) Notwithstanding subdivision (a), for the calendar years 2004 and 2005, the existing official medical fee schedule rates for physician services shall remain in effect, but these rates shall be reduced by 5 percent. The administrative director may reduce fees of individual procedures by different amounts, but in no event shall the administrative director reduce the fee for a procedure that is currently reimbursed at a rate at or below the Medicare rate for the same procedure. *Notwithstanding any other provision of this division, no rate for physician services shall be less than the Medicare rate for the same procedure.*
(l) Notwithstanding subdivision (a), the administrative director, commencing January 1, 2006, shall have the authority, after public hearings, to adopt and revise, no less frequently than biennially, an official medical fee schedule for physician services. If the administrative director fails to adopt an official medical fee schedule for physician services by January 1, 2006, the existing official medical fee schedule rates for physician services shall remain in effect until a new schedule is adopted or the existing schedule is revised.

SEC. 44. Section 5307.27 of the Labor Code is repealed.

~~5307.27. On or before December 1, 2004, the administrative director, in consultation with the Commission on Health and Safety and Workers' Compensation, shall adopt, after public hearings, a medical treatment utilization schedule, that shall incorporate the evidence-based, peer-reviewed, nationally recognized standards of care recommended by the commission pursuant to Section 77.5, and that shall address, at a minimum, the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers' compensation cases.~~

SEC. 45. Section 5307.27 of the Labor Code is added to the Labor Code :

The administrative director shall, by rule, on or before July 1, 2005, establish guidelines for the diagnosis and treatment of industrial injuries. Diagnostic and treatment guidelines shall be based upon the best available scientific evidence. In developing and promulgating these guidelines, the administrative director shall consider:
(a) Scientific evidence, including reports and studies published in peer-reviewed scientific and clinical literature, taking into consideration the nature and quality of the study, its methodology and rigorousness of design, as well as the quality of the journal in which the study was published:
(1) For treatment services, studies addressing safety, efficacy, and effectiveness of the treatment or procedure for its intended use shall be considered.
(2) For diagnostic devices or procedures, studies addressing safety, technical capacity, accuracy or utility of the device or procedure for its intended use shall be considered.
(b) National and community-based opinion, including, but not limited to, syntheses of clinical issues that may take the form of published reports in the scientific literature, national consensus documents, formalized documents addressing standards of practice, practice parameters from professional societies or commissions, and technology assessments produced by independent evidence-based practice centers. The medical director shall evaluate the nature and quality of the process used to reach consensus or produce the synthesis of expert opinion and shall take into consideration the qualifications of participants, potential biases of sponsoring organizations, the inclusion of graded scientific information in the deliberations, the explicit nature of the document, and the processes used for broader review.
(c) Advice and recommendations of formal committees made up of providers within the state. This may include recommendations from other state agencies, federal agencies and any other entity regarding studies, experience and practice with past coverage.
(d) Three months after the publication date of the updated American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines, and continuing until the effective date of treatment protocols developed pursuant to this Section, the recommended guidelines set forth in the American College of Occupational and Environmental Medical Practice Guidelines shall meet the requirements of this Section.
(e) In developing the guidelines required by this section, the medical director shall give the greatest weight to the updated American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines. If compensable medical treatment is not the subject of a treatment guideline developed by the American College of Occupational and Environmental Medicine, then the medical director shall give the greatest weight to the most rigorously designed peer-reviewed, evidence-based studies and on those studies that are reproducible as set forth in paragraph (1) of subdivision (c) of this Section.
(f) The medical director, by rule, shall periodically, but no less frequently than biennially, identify any medical treatment found to be unscientific, unproven, outmoded or experimental for purposes of determining whether such treatment is reasonable. Any treatment so identified shall be presumed to be unreasonable in any dispute involving the appropriateness of treatment.
(g) The medical director shall review and update, if necessary, the treatment guidelines no less frequently than biennially.

SEC. 46. Section 5703 of the Labor Code is amended to read:
5703. The appeals board may receive as evidence either at or subsequent to a hearing, and use as proof of any fact in dispute, the following matters, in addition to sworn testimony presented in open hearing:
(a) Reports of attending or examining physicians.

(1) Statements concerning any bill for services are admissible only if made under penalty of perjury that they are true and correct to the best knowledge of the physician.

(2) In addition, reports are admissible under this subdivision only if the physician has further stated in the body of the report that there has not been a violation of Section 139.3 and that the contents of the report are true and correct to the best knowledge of the physician. The statement shall be made under penalty of perjury.

(b) Reports of special investigators appointed by the appeals board or a workers' compensation judge to investigate and report upon any scientific or medical question.

(c) Reports of employers, containing copies of timesheets, book accounts, reports, and other records properly authenticated.

(d) Properly authenticated copies of hospital records of the case of the injured employee.

(e) All publications of the Division of Workers' Compensation.

(f) All official publications of the State of California and United States governments.

(g) Excerpts from expert testimony received by the appeals board upon similar issues of scientific fact in other cases and the prior decisions of the appeals board upon similar issues.

(h) *Treatment guidelines adopted pursuant to Section 4604.5 or 5307.27.* ~~Relevant portions of medical treatment protocols published by medical specialty societies. To be admissible, the party offering such a protocol or portion of a protocol shall concurrently enter into evidence information regarding how the protocol was developed, and to what extent the protocol is evidence-based, peer-reviewed, and nationally recognized, as required by regulations adopted by the appeals board. If a party offers into evidence a portion of a treatment protocol, any other party may offer into evidence additional portions of the protocol. The party offering a protocol, or portion thereof, into evidence shall either make a printed copy of the full protocol available for review and copying, or shall provide an Internet address at which the entire protocol may be accessed without charge.~~

SEC. 47. Section 5705.1 is added to the Labor Code, to read:

5705.1. (a) The burden of proof for the apportionment regarding permanent disability under Sections 4663, 4750, and 4750.5 shall rest upon the defendant. In accordance with Section 3202.5, the defendant shall demonstrate by a preponderance of the evidence, and by reasonable medical probability, that absent the industrial injury, the injured worker had lost, as a consequence of a preexisting injury or illness, some capacity to perform the activity affected by the injury.

(b) Notwithstanding any other provision of this code relating to workers' compensation benefits, in denying apportionment the appeals board may not, in determining permanent disability, rely on any medical report that fails to fully address the issue of apportionment and fails to set forth the basis of the medical opinion. In denying apportionment, the appeals board may not rely on any medical report that fails to apportion a previous injury or illness that has been the subject of a prior claim for damages or that fails to provide a discussion of the medical processes by which a previously asserted injury or illness resolved without affecting bodily function.

(c) If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury.

(d) The accumulation of all permanent disability awards issued to one individual employee shall not exceed 100 percent unless the employee's injury or illness is conclusively presumed to be total in character pursuant to Section 4662.

(e) Permanent disability or death benefits shall not be payable unless the industrial injury is the predominant cause of the disability or death when compared to all causes of injury in total.

SEC. 48. Section 5814 of the Labor Code is repealed.

~~5814. When payment of compensation has been unreasonably delayed or refused, either prior to or subsequent to the issuance of an award, the full amount of the order, decision, or award shall be increased by 10 percent. Multiple increases shall not be awarded for repeated delays in making a series of payments due for the same type or specie of benefit unless there has been a legally significant event between the delay and the subsequent delay in payments of the same type or specie of benefits. The question of delay and the reasonableness of the cause therefor shall be determined by the appeals board in accordance with the facts. This delay or refusal shall constitute good cause under Section 5803 to rescind, alter, or amend the order, decision, or award for the purpose of making the increase provided for herein.~~

SEC. 49. Section 5814 is added to the Labor Code, to read:

5814. (a) When payment of compensation has been unreasonably delayed or refused, either prior to or subsequent to the issuance of an award, the amount of the payment unreasonably delayed or refused may be increased up to 15 percent or up to five hundred dollars ($500), whichever is greater. In proceeding under this section, the appeals board shall use its discretion to accomplish a fair balance and substantial justice between the parties.

(b) As a precondition to a claim for penalties under this section, the employee shall give written notice to the employer of the claimed unreasonable delay or refusal of payment of compensation. If, within 20 days from the date of services of this notice, the employer pays a self-imposed increase of 10 percent of the amount of payment delayed or refused, in addition to any other self-imposed increases due under this division, there shall be no further penalty allowed under this section. If the employer disputes whether the delay or refusal is unreasonable, and the workers' compensation administrative law judge determines that the delay or refusal violates this section, the workers' compensation administrative law judge shall award the penalty prescribed in subdivision (a). In determining whether the delay or refusal is unreasonable, the workers' compensation administrative law judge shall consider only the specific facts resulting in the delay or refusal of the specific payment that is the subject of the request for penalties.

(c) The appeals board shall have no jurisdiction to hear a claim for penalties under subdivision (a), unless the employee files a claim for a penalty within one year from the date of the alleged unreasonable delay or refusal to pay benefits. Upon the approval of a compromise and release by the appeals board, it shall be conclusively presumed that any existing or potential penalties have been resolved, unless expressly excluded by the terms of the compromise and release.

(d) When a penalty is awarded under subdivision (a), the appeals board may allow a credit for any self-imposed increase under subdivision (d) of Section 4650 or subdivision (b), in order to accomplish a fair balance and substantial justice between the parties.

(e) Nothing in this section shall be construed to create a civil cause of action.

SEC. 50. Section 5814.5 of the Labor Code is repealed.

~~5814.5. When the payment of compensation has been unreasonably delayed or refused subsequent to the issuance of an award by an employer that has secured the payment of compensation pursuant to Section 3700, the appeals board shall, in addition to increasing the order, decision, or award pursuant to Section 5814, award reasonable attorneys' fees incurred in enforcing the payment of compensation awarded.~~

SEC. 51. Section 6401.7 of the Labor Code is amended to read:

6401.7. (a) Every employer shall establish, implement, and maintain an effective injury prevention program. The program shall be written, except as provided in subdivision (e), and shall include, but not be limited to, the following elements:

(1) Identification of the person or persons responsible for implementing the program.

(2) The employer's system for identifying and evaluating workplace hazards, including scheduled periodic inspections to identify unsafe conditions and work practices.

(3) The employer's methods and procedures for correcting unsafe or unhealthy conditions and work practices in a timely manner.

(4) An occupational health and safety training program designed to instruct employees in general safe and healthy work practices and to provide specific instruction with respect to hazards specific to each employee's job assignment.

(5) The employer's system for communicating with employees on occupational health and safety matters, including provisions designed to encourage employees to inform the employer of hazards at the worksite without fear of reprisal.

(6) The employer's system for ensuring that employees comply with safe and healthy work practices, which may include disciplinary action.

(b) The employer shall correct unsafe and unhealthy conditions and work practices in a timely manner based on the severity of the hazard.

(c) The employer shall train all employees when the training program is first established, all new employees, and all employees given a new job assignment, and shall train employees whenever new substances, processes, procedures, or equipment are introduced to the workplace and represent a new hazard, and whenever the employer receives notification of a new or previously unrecognized hazard. Beginning January 1, 1994, an employer in the construction industry who is required to be licensed under Chapter 9 (commencing with Section 7000) of Division 3 of the Business and Professions Code may use employee training provided to the employer's employees under a construction industry occupational safety and health training program approved by the division to comply with the requirements of subdivision (a) relating to employee training, and shall only be required to provide training on hazards specific to an employee's job duties.

(d) The employer shall keep appropriate records of steps taken to implement and maintain the program. Beginning January 1, 1994, an employer in the construction industry who is required to be licensed under Chapter 9 (commencing with Section 7000) of Division 3 of the Business and Professions Code may use records relating to employee training provided to the employer in connection with an occupational safety and health training program approved by the division to comply with the requirements of this subdivision, and shall only be required to keep records of those steps taken to implement and maintain the program with respect to hazards specific to an employee's job duties.

(e) (1) The standards board shall adopt a standard setting forth the employer's duties under this section, on or before January 1, 1991, consistent with the requirements specified in subdivisions (a), (b), (c), and (d). The standards board, in adopting the standard, shall include substantial compliance criteria for use in evaluating an employer's injury prevention program. The board may adopt less stringent criteria for employers with few employees and for employers in industries with insignificant occupational safety or health hazards.

(2) Notwithstanding subdivision (a), for employers with fewer than 20 employees who are in industries that are not on a designated list of high hazard industries and who have a workers' compensation experience modification rate of 1.1 or less, and for any employers with fewer than 20 employees who are in industries that are on a designated list of low hazard industries, the board shall adopt a standard setting forth the employer's duties under this section consistent with the requirements specified in subdivisions (a), (b), and (c), except that the standard shall only require written documentation to the extent of documenting the person or persons responsible for implementing the program pursuant to paragraph (1) of subdivision (a), keeping a record of periodic inspections pursuant to paragraph (2) of subdivision (a), and keeping a record of employee training pursuant to paragraph (4) of subdivision (a). To any extent beyond the specifications of this subdivision, the standard shall not require the employer to keep the records specified in subdivision (d).

(3) The division shall establish a list of high hazard industries using the methods prescribed in Section 6314.1 for identifying and targeting employers in high hazard industries. For purposes of this subdivision, the "designated list of high hazard industries" shall be the list established pursuant to this paragraph.

For the purpose of implementing this subdivision, the Department of Industrial Relations shall periodically review, and as necessary revise, the list.

(4) For the purpose of implementing this subdivision, the Department of Industrial Relations shall also establish a list of low hazard industries, and shall periodically review, and as necessary revise, that list.

(f) The standard adopted pursuant to subdivision (e) shall specifically permit employer and employee occupational safety and health committees to be included in the employer's injury prevention program. The board shall establish criteria for use in evaluating employer and employee occupational safety and health committees. The criteria shall include minimum duties, including the following:

(1) Review of the employer's (A) periodic, scheduled worksite

inspections, (B) investigation of causes of incidents resulting in injury, illness, or exposure to hazardous substances, and (C) investigation of any alleged hazardous condition brought to the attention of any committee member. When determined necessary by the committee, the committee may conduct its own inspections and investigations.

(2) Upon request from the division, verification of abatement action taken by the employer as specified in division citations.

If an employer's occupational safety and health committee meets the criteria established by the board, it shall be presumed to be in substantial compliance with paragraph (5) of subdivision (a).

(g) The division shall adopt regulations specifying the procedures for selecting employee representatives for employer-employee occupational health and safety committees when these procedures are not specified in an applicable collective bargaining agreement. No employee or employee organization shall be held liable for any act or omission in connection with a health and safety committee.

(h) The employer's injury prevention program, as required by this section, shall cover all of the employer's employees and all other workers who the employer controls or directs and directly supervises on the job to the extent these workers are exposed to worksite and job assignment specific hazards. Nothing in this subdivision shall affect the obligations of a contractor or other employer which controls or directs and directly supervises its own employees on the job.

(i) Where a contractor supplies its employee to a state agency employer on a temporary basis, the state agency employer may assess a fee upon the contractor to reimburse the state agency for the additional costs, if any, of including the contract employee within the state agency's injury prevention program.

(j) (1) The division shall prepare a Model Injury and Illness Prevention Program for Non-High-Hazard Employment, and shall make copies of the model program prepared pursuant to this subdivision available to employers, upon request, for posting in the workplace. An employer who adopts and implements the model program prepared by the division pursuant to this paragraph in good faith shall not be assessed a civil penalty for the first citation for a violation of this section issued after the employer's adoption and implementation of the model program.

(2) For purposes of this subdivision, the division shall establish a list of non-high-hazard industries in California, that may include the industries that, pursuant to Section 14316 of Title 8 of the California Code of Regulations, are not currently required to keep records of occupational injuries and illnesses under Article 2 (commencing with Section 14301) of Subchapter 1 of Chapter 7 of Division 1 of Title 8 of the California Code of Regulations. These industries, identified by their Standard Industrial Classification Codes, as published by the United States Office of Management and Budget in the Manual of Standard Industrial Classification Codes, 1987 Edition, are apparel and accessory stores (Code 56), eating and drinking places (Code 58), miscellaneous retail (Code 59), finance, insurance, and real estate (Codes 60-67), personal services (Code 72), business services (Code 73), motion pictures (Code 78) except motion picture production and allied services (Code 781), legal services (Code 81), educational services (Code 82), social services (Code 83), museums, art galleries, and botanical and zoological gardens (Code 84), membership organizations (Code 86), engineering, accounting, research, management, and related services (Code 87), private households (Code 88), and miscellaneous services (Code 89). To further identify industries that may be included on the list, the division shall also consider data from a rating organization, as defined in Section 11750.1 of the Insurance Code, the Division of Labor Statistics and Research, including the logs of occupational injuries and illnesses maintained by employers on Form CAL/OSHA No. 200, or its equivalent, as required by Section 14301 of Title 8 of the California Code of Regulations, and all other appropriate information. The list shall be established by June 30, 1994, and shall be reviewed, and as necessary revised, biennially.

(3) The division shall prepare a Model Injury and Illness Prevention Program for Employers in Industries with Intermittent Employment, and shall determine which industries have historically utilized seasonal or intermittent employees. An employer in an industry determined by the division to have historically utilized seasonal or intermittent employees shall be deemed to have complied with the requirements of subdivision (a) with respect to a written injury prevention program if the employer adopts the model program prepared by the division pursuant to this paragraph and complies with any instructions relating thereto.

(k) With respect to any county, city, city and county, or district, or any public or quasi-public corporation or public agency therein, including any public entity, other than a state agency, that is a member of, or created by, a joint powers agreement, subdivision (d) shall not apply.

~~(l) Every workers' compensation insurer shall conduct a review, including a written report as specified below, of the injury and illness prevention program (IIPP) of each of its insureds within four months of the commencement of the initial insurance policy term. The review shall determine whether the insured has implemented all of the required components of the IIPP, and evaluate their effectiveness. The training component of the IIPP shall be evaluated to determine whether training is provided to line employees, supervisors, and upper level management, and effectively imparts the information and skills each of these groups needs to ensure that all of the insured's specific health and safety issues are fully addressed by the insured. The reviewer shall prepare a detailed written report specifying the findings of the review and all recommended changes deemed necessary to make the IIPP effective. The reviewer shall be an independent licensed California professional engineer, certified safety professional, or a certified industrial hygienist.~~

SEC. 52. This Act may be amended or repealed by the procedures set forth in this section. If any portion of subdivision (a) is declared invalid, then subdivision (b) shall be the exclusive means of amending or repealing this title.

(a) This title may be amended to further its purposes by statute, passed in each house by rollcall vote entered in the journal, majority of the membership concurring and sign by the Governor, if at least 12 days prior to passage in each house the bill in its final form has been delivered to the Secretary of the Labor and Workforce Development Agency, or its successor agency, for distribution to the news media and to every person who has requested the Labor and Workforce Development Agency to send copies of such bills to him or her. (b)

This title may be amended or repealed by a statute that becomes effective only when approved by the electors.

SEC. 53. The provisions of this act are severable. If any of this act or its application is held invalid, that invalidity shall not affect other provisions or application that can be given effect without the invalid provision or application.